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Calendar No. **175**

AMENDMENT NO. **2786**

Purpose: In the nature of a substitute.

IN THE SENATE OF THE UNITED STATES—111th Cong., 1st Sess.

H. R. 3590

To amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

November 19, 2009

Ordered to lie on the table and to be printed

Amendment in the nature of a substitute intended to be proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN)

Viz:

1 Strike all after the enacting clause and insert the fol-
2 lowing:

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the
5 ''Patient Protection and Affordable Care Act''.

6 (b) TABLE OF CONTENTS.—The table of contents of
7 this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS

Subtitle A—Immediate Improvements in Health Care Coverage for All Americans

Sec. 1001. Amendments to the Public Health Service Act.

"PART A—INDIVIDUAL AND GROUP MARKET REFORMS

"SUBPART II—IMPROVING COVERAGE

"Sec. 2711. No lifetime or annual limits.
"Sec. 2712. Prohibition on rescissions.
"Sec. 2713. Coverage of preventive health services.
"Sec. 2714. Extension of dependent coverage.
"Sec. 2715. Development and utilization of uniform explanation of coverage documents and standardized definitions.
"Sec. 2716. Prohibition of discrimination based on salary.
"Sec. 2717. Ensuring the quality of care.
"Sec. 2718. Bringing down the cost of health care coverage.
"Sec. 2719. Appeals process.
Sec. 1002. Health insurance consumer information.
Sec. 1003. Ensuring that consumers get value for their dollars.
Sec. 1004. Effective dates.

Subtitle B—Immediate Actions to Preserve and Expand Coverage

Sec. 1101. Immediate access to insurance for uninsured individuals with a preexisting condition.
Sec. 1102. Reinsurance for early retirees.
Sec. 1103. Immediate information that allows consumers to identify affordable coverage options.
Sec. 1104. Administrative simplification.
Sec. 1105. Effective date.

Subtitle C—Quality Health Insurance Coverage for All Americans

PART I—HEALTH INSURANCE MARKET REFORMS

Sec. 1201. Amendment to the Public Health Service Act.

"SUBPART I—GENERAL REFORM

"Sec. 2701. Fair health insurance premiums.
"Sec. 2702. Guaranteed availability of coverage.
"Sec. 2703. Guaranteed renewability of coverage.
"Sec. 2704. Prohibition of preexisting condition exclusions or other discrimination based on health status.
"Sec. 2705. Prohibiting discrimination against individual participants and beneficiaries based on health status.
"Sec. 2706. Non-discrimination in health care.
"Sec. 2707. Comprehensive health insurance coverage.
"Sec. 2708. Prohibition on excessive waiting periods.

PART II—OTHER PROVISIONS

Sec. 1251. Preservation of right to maintain existing coverage.
Sec. 1252. Rating reforms must apply uniformly to all health insurance issuers and group health plans.
Sec. 1253. Effective dates.

Subtitle D—Available Coverage Choices for All Americans

PART I—Establishment of Qualified Health Plans

Sec. 1301. Qualified health plan defined.
Sec. 1302. Essential health benefits requirements.
Sec. 1303. Special rules.
Sec. 1304. Related definitions.

PART II—Consumer Choices and Insurance Competition Through Health Benefit Exchanges

Sec. 1311. Affordable choices of health benefit plans.
Sec. 1312. Consumer choice.
Sec. 1313. Financial integrity.

PART III—State Flexibility Relating to Exchanges

Sec. 1321. State flexibility in operation and enforcement of Exchanges and related requirements.
Sec. 1322. Federal program to assist establishment and operation of nonprofit, member-run health insurance issuers.
Sec. 1323. Community health insurance option.
Sec. 1324. Level playing field.

PART IV—State Flexibility to Establish Alternative Programs

Sec. 1331. State flexibility to establish basic health programs for low-income individuals not eligible for Medicaid.
Sec. 1332. Waiver for State innovation.
Sec. 1333. Provisions relating to offering of plans in more than one State.

PART V—Reinsurance and Risk Adjustment

Sec. 1341. Transitional reinsurance program for individual and small group markets in each State.
Sec. 1342. Establishment of risk corridors for plans in individual and small group markets.
Sec. 1343. Risk adjustment.

Subtitle E—Affordable Coverage Choices for All Americans

PART I—Premium Tax Credits and Cost-sharing Reductions

SUBPART A—PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS

Sec. 1401. Refundable tax credit providing premium assistance for coverage under a qualified health plan.
Sec. 1402. Reduced cost-sharing for individuals enrolling in qualified health plans.

SUBPART B—ELIGIBILITY DETERMINATIONS

Sec. 1411. Procedures for determining eligibility for Exchange participation, premium tax credits and reduced cost-sharing , and individual responsibility exemptions.
Sec. 1412. Advance determination and payment of premium tax credits and cost-sharing reductions.

Sec. 1413. Streamlining of procedures for enrollment through an exchange and State Medicaid, CHIP, and health subsidy programs.
Sec. 1414. Disclosures to carry out eligibility requirements for certain programs.
Sec. 1415. Premium tax credit and cost-sharing reduction payments disregarded for Federal and Federally-assisted programs.

PART II—SMALL BUSINESS TAX CREDIT

Sec. 1421. Credit for employee health insurance expenses of small businesses.

Subtitle F—Shared Responsibility for Health Care

PART I—INDIVIDUAL RESPONSIBILITY

Sec. 1501. Requirement to maintain minimum essential coverage.
Sec. 1502. Reporting of health insurance coverage.

PART II—EMPLOYER RESPONSIBILITIES

Sec. 1511. Automatic enrollment for employees of large employers.
Sec. 1512. Employer requirement to inform employees of coverage options.
Sec. 1513. Shared responsibility for employers.
Sec. 1514. Reporting of employer health insurance coverage.
Sec. 1515. Offering of Exchange-participating qualified health plans through cafeteria plans.

Subtitle G—Miscellaneous Provisions

Sec. 1551. Definitions.
Sec. 1552. Transparency in government.
Sec. 1553. Prohibition against discrimination on assisted suicide.
Sec. 1554. Access to therapies.
Sec. 1555. Freedom not to participate in Federal health insurance programs.
Sec. 1556. Equity for certain eligible survivors.
Sec. 1557. Nondiscrimination.
Sec. 1558. Protections for employees.
Sec. 1559. Oversight.
Sec. 1560. Rules of construction.
Sec. 1561. Health information technology enrollment standards and protocols.
Sec. 1562. Conforming amendments.

TITLE II—ROLE OF PUBLIC PROGRAMS

Subtitle A—Improved Access to Medicaid

Sec. 2001. Medicaid coverage for the lowest income populations.
Sec. 2002. Income eligibility for nonelderly determined using modified gross income.
Sec. 2003. Requirement to offer premium assistance for employer-sponsored insurance.
Sec. 2004. Medicaid coverage for former foster care children.
Sec. 2005. Payments to territories.
Sec. 2006. Special adjustment to FMAP determination for certain States recovering from a major disaster.
Sec. 2007. Medicaid Improvement Fund rescission.

Subtitle B—Enhanced Support for the Children's Health Insurance Program

Sec. 2101. Additional federal financial participation for CHIP.
Sec. 2102. Technical corrections.

Subtitle C—Medicaid and CHIP Enrollment Simplification

Sec. 2201. Enrollment Simplification and coordination with State Health Insurance Exchanges.
Sec. 2202. Permitting hospitals to make presumptive eligibility determinations for all Medicaid eligible populations.

Subtitle D—Improvements to Medicaid Services

Sec. 2301. Coverage for freestanding birth center services.
Sec. 2302. Concurrent care for children.
Sec. 2303. State eligibility option for family planning services.
Sec. 2304. Clarification of definition of medical assistance.

Subtitle E—New Options for States to Provide Long-Term Services and Supports

Sec. 2401. Community First Choice Option.
Sec. 2402. Removal of barriers to providing home and community-based services.
Sec. 2403. Money Follows the Person Rebalancing Demonstration.
Sec. 2404. Protection for recipients of home and community-based services against spousal impoverishment.
Sec. 2405. Funding to expand State Aging and Disability Resource Centers.
Sec. 2406. Sense of the Senate regarding long-term care.

Subtitle F—Medicaid Prescription Drug Coverage

Sec. 2501. Prescription drug rebates.
Sec. 2502. Elimination of exclusion of coverage of certain drugs.
Sec. 2503. Providing adequate pharmacy reimbursement.

Subtitle G—Medicaid Disproportionate Share Hospital (DSH) Payments

Sec. 2551. Disproportionate share hospital payments.

Subtitle H—Improved Coordination for Dual Eligible Beneficiaries

Sec. 2601. 5-year period for demonstration projects.
Sec. 2602. Providing Federal coverage and payment coordination for dual eligible beneficiaries.

Subtitle I—Improving the Quality of Medicaid for Patients and Providers

Sec. 2701. Adult health quality measures.
Sec. 2702. Payment Adjustment for Health Care-Acquired Conditions.
Sec. 2703. State option to provide health homes for enrollees with chronic conditions.
Sec. 2704. Demonstration project to evaluate integrated care around a hospitalization.
Sec. 2705. Medicaid Global Payment System Demonstration Project.
Sec. 2706. Pediatric Accountable Care Organization Demonstration Project.
Sec. 2707. Medicaid emergency psychiatric demonstration project.

Subtitle J—Improvements to the Medicaid and CHIP Payment and Access Commission (MACPAC)

Sec. 2801. MACPAC assessment of policies affecting all Medicaid beneficiaries.

Subtitle K—Protections for American Indians and Alaska Natives

Sec. 2901. Special rules relating to Indians.
Sec. 2902. Elimination of sunset for reimbursement for all medicare part B services furnished by certain indian hospitals and clinics.

Subtitle L—Maternal and Child Health Services

Sec. 2951. Maternal, infant, and early childhood home visiting programs.
Sec. 2952. Support, education, and research for postpartum depression.
Sec. 2953. Personal responsibility education.
Sec. 2954. Restoration of funding for abstinence education.
Sec. 2955. Inclusion of information about the importance of having a health care power of attorney in transition planning for children aging out of foster care and independent living programs.

TITLE III—IMPROVING THE QUALITY AND EFFICIENCY OF HEALTH CARE

Subtitle A—Transforming the Health Care Delivery System

PART I—Linking Payment to Quality Outcomes Under the Medicare Program

Sec. 3001. Hospital Value-Based purchasing program.
Sec. 3002. Improvements to the physician quality reporting system.
Sec. 3003. Improvements to the physician feedback program.
Sec. 3004. Quality reporting for long-term care hospitals, inpatient rehabilitation hospitals, and hospice programs.
Sec. 3005. Quality reporting for PPS-exempt cancer hospitals.
Sec. 3006. Plans for a Value-Based purchasing program for skilled nursing facilities and home health agencies.
Sec. 3007. Value-based payment modifier under the physician fee schedule.
Sec. 3008. Payment adjustment for conditions acquired in hospitals.

PART II—National Strategy to Improve Health Care Quality

Sec. 3011. National strategy.
Sec. 3012. Interagency Working Group on Health Care Quality.
Sec. 3013. Quality measure development.
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PART III—Encouraging Development of New Patient Care Models

Sec. 3021. Establishment of Center for Medicare and Medicaid Innovation within CMS.
Sec. 3022. Medicare shared savings program.
Sec. 3023. National pilot program on payment bundling.
Sec. 3024. Independence at home demonstration program.
Sec. 3025. Hospital readmissions reduction program.
Sec. 3026. Community-Based Care Transitions Program.
Sec. 3027. Extension of gainsharing demonstration.

Subtitle B—Improving Medicare for Patients and Providers

PART I—ENSURING BENEFICIARY ACCESS TO PHYSICIAN CARE AND OTHER SERVICES

Sec. 3101. Increase in the physician payment update.
Sec. 3102. Extension of the work geographic index floor and revisions to the practice expense geographic adjustment under the Medicare physician fee schedule.
Sec. 3103. Extension of exceptions process for Medicare therapy caps.
Sec. 3104. Extension of payment for technical component of certain physician pathology services.
Sec. 3105. Extension of ambulance add-ons.
Sec. 3106. Extension of certain payment rules for long-term care hospital services and of moratorium on the establishment of certain hospitals and facilities.
Sec. 3107. Extension of physician fee schedule mental health add-on.
Sec. 3108. Permitting physician assistants to order post-Hospital extended care services.
Sec. 3109. Exemption of certain pharmacies from accreditation requirements.
Sec. 3110. Part B special enrollment period for disabled TRICARE beneficiaries.
Sec. 3111. Payment for bone density tests.
Sec. 3112. Revision to the Medicare Improvement Fund.
Sec. 3113. Treatment of certain complex diagnostic laboratory tests.
Sec. 3114. Improved access for certified nurse-midwife services.

PART II—RURAL PROTECTIONS

Sec. 3121. Extension of outpatient hold harmless provision.
Sec. 3122. Extension of Medicare reasonable costs payments for certain clinical diagnostic laboratory tests furnished to hospital patients in certain rural areas.
Sec. 3123. Extension of the Rural Community Hospital Demonstration Program.
Sec. 3124. Extension of the Medicare-dependent hospital (MDH) program.
Sec. 3125. Temporary improvements to the Medicare inpatient hospital payment adjustment for low-volume hospitals.
Sec. 3126. Improvements to the demonstration project on community health integration models in certain rural counties.
Sec. 3127. MedPAC study on adequacy of Medicare payments for health care providers serving in rural areas.
Sec. 3128. Technical correction related to critical access hospital services.
Sec. 3129. Extension of and revisions to Medicare rural hospital flexibility program.

PART III—IMPROVING PAYMENT ACCURACY

Sec. 3131. Payment adjustments for home health care.
Sec. 3132. Hospice reform.
Sec. 3133. Improvement to medicare disproportionate share hospital (DSH) payments.
Sec. 3134. Misvalued codes under the physician fee schedule.
Sec. 3135. Modification of equipment utilization factor for advanced imaging services.
Sec. 3136. Revision of payment for power-driven wheelchairs.
Sec. 3137. Hospital wage index improvement.
Sec. 3138. Treatment of certain cancer hospitals.

Sec. 3139. Payment for biosimilar biological products.
Sec. 3140. Medicare hospice concurrent care demonstration program.
Sec. 3141. Application of budget neutrality on a national basis in the calculation of the Medicare hospital wage index floor.
Sec. 3142. HHS study on urban Medicare-dependent hospitals.

Subtitle C—Provisions Relating to Part C

Sec. 3201. Medicare Advantage payment.
Sec. 3202. Benefit protection and simplification.
Sec. 3203. Application of coding intensity adjustment during MA payment transition.
Sec. 3204. Simplification of annual beneficiary election periods.
Sec. 3205. Extension for specialized MA plans for special needs individuals.
Sec. 3206. Extension of reasonable cost contracts.
Sec. 3207. Technical correction to MA private fee-for-service plans.
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Sec. 3209. Authority to deny plan bids.
Sec. 3210. Development of new standards for certain Medigap plans.

Subtitle D—Medicare Part D Improvements for Prescription Drug Plans and MA–PD Plans

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Sec. 3302. Improvement in determination of Medicare part D low-income benchmark premium.
Sec. 3303. Voluntary de minimis policy for subsidy eligible individuals under prescription drug plans and MA–PD plans.
Sec. 3304. Special rule for widows and widowers regarding eligibility for low-income assistance.
Sec. 3305. Improved information for subsidy eligible individuals reassigned to prescription drug plans and MA–PD plans.
Sec. 3306. Funding outreach and assistance for low-income programs.
Sec. 3307. Improving formulary requirements for prescription drug plans and MA–PD plans with respect to certain categories or classes of drugs.
Sec. 3308. Reducing part D premium subsidy for high-income beneficiaries.
Sec. 3309. Elimination of cost sharing for certain dual eligible individuals.
Sec. 3310. Reducing wasteful dispensing of outpatient prescription drugs in long-term care facilities under prescription drug plans and MA–PD plans.
Sec. 3311. Improved Medicare prescription drug plan and MA–PD plan complaint system.
Sec. 3312. Uniform exceptions and appeals process for prescription drug plans and MA–PD plans.
Sec. 3313. Office of the Inspector General studies and reports.
Sec. 3314. Including costs incurred by AIDS drug assistance programs and Indian Health Service in providing prescription drugs toward the annual out-of-pocket threshold under part D.
Sec. 3315. Immediate reduction in coverage gap in 2010.

Subtitle E—Ensuring Medicare Sustainability

Sec. 3401. Revision of certain market basket updates and incorporation of productivity improvements into market basket updates that do not already incorporate such improvements.

Sec. 3402. Temporary adjustment to the calculation of part B premiums.
Sec. 3403. Independent Medicare Advisory Board.

Subtitle F—Health Care Quality Improvements

Sec. 3501. Health care delivery system research; Quality improvement technical assistance.
Sec. 3502. Establishing community health teams to support the patient-centered medical home.
Sec. 3503. Medication management services in treatment of chronic disease.
Sec. 3504. Design and implementation of regionalized systems for emergency care.
Sec. 3505. Trauma care centers and service availability.
Sec. 3506. Program to facilitate shared decisionmaking.
Sec. 3507. Presentation of prescription drug benefit and risk information.
Sec. 3508. Demonstration program to integrate quality improvement and patient safety training into clinical education of health professionals.
Sec. 3509. Improving women's health.
Sec. 3510. Patient navigator program.
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TITLE IV—PREVENTION OF CHRONIC DISEASE AND IMPROVING PUBLIC HEALTH

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Sec. 4002. Prevention and Public Health Fund.
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Subtitle B—Increasing Access to Clinical Preventive Services

Sec. 4101. School-based health centers.
Sec. 4102. Oral healthcare prevention activities.
Sec. 4103. Medicare coverage of annual wellness visit providing a personalized prevention plan.
Sec. 4104. Removal of barriers to preventive services in Medicare.
Sec. 4105. Evidence-based coverage of preventive services in Medicare.
Sec. 4106. Improving access to preventive services for eligible adults in Medicaid.
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Subtitle C—Increasing the Supply of the Health Care Workforce

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Sec. 5302. Training opportunities for direct care workers.
Sec. 5303. Training in general, pediatric, and public health dentistry.
Sec. 5304. Alternative dental health care providers demonstration project.
Sec. 5305. Geriatric education and training; career awards; comprehensive geriatric education.
Sec. 5306. Mental and behavioral health education and training grants.
Sec. 5307. Cultural competency, prevention, and public health and individuals with disabilities training.
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Sec. 6103. Nursing home compare Medicare website.
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Sec. 6107. GAO study and report on Five-Star Quality Rating System.

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Sec. 6111. Civil money penalties.
Sec. 6112. National independent monitor demonstration project.
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Subtitle C—Nationwide Program for National and State Background Checks on Direct Patient Access Employees of Long-term Care Facilities and Providers

Sec. 6201. Nationwide program for National and State background checks on direct patient access employees of long-term care facilities and providers.

Subtitle D—Patient-Centered Outcomes Research

Sec. 6301. Patient-Centered Outcomes Research.
Sec. 6302. Federal coordinating council for comparative effectiveness research.

Subtitle E—Medicare, Medicaid, and CHIP Program Integrity Provisions

Sec. 6401. Provider screening and other enrollment requirements under Medicare, Medicaid, and CHIP.
Sec. 6402. Enhanced Medicare and Medicaid program integrity provisions.
Sec. 6403. Elimination of duplication between the Healthcare Integrity and Protection Data Bank and the National Practitioner Data Bank.
Sec. 6404. Maximum period for submission of Medicare claims reduced to not more than 12 months.
Sec. 6405. Physicians who order items or services required to be Medicare enrolled physicians or eligible professionals.
Sec. 6406. Requirement for physicians to provide documentation on referrals to programs at high risk of waste and abuse.
Sec. 6407. Face to face encounter with patient required before physicians may certify eligibility for home health services or durable medical equipment under Medicare.
Sec. 6408. Enhanced penalties.
Sec. 6409. Medicare self-referral disclosure protocol.
Sec. 6410. Adjustments to the Medicare durable medical equipment, prosthetics, orthotics, and supplies competitive acquisition program.

Sec. 6411. Expansion of the Recovery Audit Contractor (RAC) program.

Subtitle F—Additional Medicaid Program Integrity Provisions

Sec. 6501. Termination of provider participation under Medicaid if terminated under Medicare or other State plan.
Sec. 6502. Medicaid exclusion from participation relating to certain ownership, control, and management affiliations.
Sec. 6503. Billing agents, clearinghouses, or other alternate payees required to register under Medicaid.
Sec. 6504. Requirement to report expanded set of data elements under MMIS to detect fraud and abuse.
Sec. 6505. Prohibition on payments to institutions or entities located outside of the United States.
Sec. 6506. Overpayments.
Sec. 6507. Mandatory State use of national correct coding initiative.
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Subtitle G—Additional Program Integrity Provisions

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Sec. 6602. Clarifying definition.
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Sec. 6604. Applicability of State law to combat fraud and abuse.
Sec. 6605. Enabling the Department of Labor to issue administrative summary cease and desist orders and summary seizures orders against plans that are in financially hazardous condition.
Sec. 6607. Permitting evidentiary privilege and confidential cSec. 6606. MEWA plan registration with Department of Labor.
ommunications.

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Sec. 6701. Short title of subtitle.
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Sec. 6801. Sense of the Senate regarding medical malpractice.

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Sec. 7103. GAO study to make recommendations on improving the 340B program.

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Sec. 9002. Inclusion of cost of employer-sponsored health coverage on W–2.
Sec. 9003. Distributions for medicine qualified only if for prescribed drug or insulin.
Sec. 9004. Increase in additional tax on distributions from HSAs and Archer MSAs not used for qualified medical expenses.
Sec. 9005. Limitation on health flexible spending arrangements under cafeteria plans.
Sec. 9006. Expansion of information reporting requirements.
Sec. 9007. Additional requirements for charitable hospitals.
Sec. 9008. Imposition of annual fee on branded prescription pharmaceutical manufacturers and importers.
Sec. 9009. Imposition of annual fee on medical device manufacturers and importers.
Sec. 9010. Imposition of annual fee on health insurance providers.
Sec. 9011. Study and report of effect on veterans health care.
Sec. 9012. Elimination of deduction for expenses allocable to Medicare Part D subsidy.
Sec. 9013. Modification of itemized deduction for medical expenses.
Sec. 9014. Limitation on excessive remuneration paid by certain health insurance providers.
Sec. 9015. Additional hospital insurance tax on high-income taxpayers.
Sec. 9016. Modification of section 833 treatment of certain health organizations.
Sec. 9017. Excise tax on elective cosmetic medical procedures.

Subtitle B—Other Provisions

Sec. 9021. Exclusion of health benefits provided by Indian tribal governments.
Sec. 9022. Establishment of simple cafeteria plans for small businesses.
Sec. 9023. Qualifying therapeutic discovery project credit.

TITLE I—QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS

Subtitle A—Immediate Improvements in Health Care Coverage for All Americans

SEC. 1001. AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT.

Part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.) is amended—

(1) by striking the part heading and inserting the following:

"PART A—INDIVIDUAL AND GROUP MARKET REFORMS";

(2) by redesignating sections 2704 through 2707 as sections 2725 through 2728, respectively;

(3) by redesignating sections 2711 through 2713 as sections 2731 through 2733, respectively;

(4) by redesignating sections 2721 through 2723 as sections 2735 through 2737, respectively; and

(5) by inserting after section 2702, the following:

1 **"Subpart II—Improving Coverage**

2 **"SEC. 2711. NO LIFETIME OR ANNUAL LIMITS.**

3 ''(a) IN GENERAL.—A group health plan and a health
4 insurance issuer offering group or individual health insur-
5 ance coverage may not establish—

6 ''(1) lifetime limits on the dollar value of bene-
7 fits for any participant or beneficiary; or

8 ''(2) unreasonable annual limits (within the
9 meaning of section 223 of the Internal Revenue
10 Code of 1986) on the dollar value of benefits for any
11 participant or beneficiary.

12 ''(b) PER BENEFICIARY LIMITS.—Subsection (a)
13 shall not be construed to prevent a group health plan or
14 health insurance coverage that is not required to provide
15 essential health benefits under section 1302(b) of the Pa-
16 tient Protection and Affordable Care Act from placing an-
17 nual or lifetime per beneficiary limits on specific covered
18 benefits to the extent that such limits are otherwise per-
19 mitted under Federal or State law.

20 **"SEC. 2712. PROHIBITION ON RESCISSIONS.**

21 ''A group health plan and a health insurance issuer
22 offering group or individual health insurance coverage
23 shall not rescind such plan or coverage with respect to an
24 enrollee once the enrollee is covered under such plan or
25 coverage involved, except that this section shall not apply
26 to a covered individual who has performed an act or prac-

1 tice that constitutes fraud or makes an intentional mis-
2 representation of material fact as prohibited by the terms
3 of the plan or coverage. Such plan or coverage may not
4 be cancelled except with prior notice to the enrollee, and
5 only as permitted under section 2702(c) or 2742(b).

6 **"SEC. 2713. COVERAGE OF PREVENTIVE HEALTH SERVICES.**

7 "(a) IN GENERAL.—A group health plan and a health
8 insurance issuer offering group or individual health insur-
9 ance coverage shall provide coverage for and shall not im-
10 pose any cost sharing requirements for—

11 "(1) evidence-based items or services that have
12 in effect a rating of 'A' or 'B' in the current rec-
13 ommendations of the United States Preventive Serv-
14 ices Task Force;

15 "(2) immunizations that have in effect a rec-
16 ommendation from the Advisory Committee on Im-
17 munization Practices of the Centers for Disease
18 Control and Prevention with respect to the indi-
19 vidual involved; and

20 "(3) with respect to infants, children, and ado-
21 lescents, evidence-informed preventive care and
22 screenings provided for in the comprehensive guide-
23 lines supported by the Health Resources and Serv-
24 ices Administration.

25 "(b) INTERVAL.—

"(1) IN GENERAL.—The Secretary shall establish a minimum interval between the date on which a recommendation described in subsection (a)(1) or (a)(2) or a guideline under subsection (a)(3) is issued and the plan year with respect to which the requirement described in subsection (a) is effective with respect to the service described in such recommendation or guideline.

"(2) MINIMUM.—The interval described in paragraph (1) shall not be less than 1 year.

"(c) VALUE-BASED INSURANCE DESIGN.—The Secretary may develop guidelines to permit a group health plan and a health insurance issuer offering group or individual health insurance coverage to utilize value-based insurance designs.

"SEC. 2714. EXTENSION OF DEPENDENT COVERAGE.

"(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage that provides dependent coverage of children shall continue to make such coverage available for an adult child (who is not married) until the child turns 26 years of age. Nothing in this section shall require a health plan or a health insurance issuer described in the preceding sentence to make coverage available for a child of a child receiving dependent coverage.

1 "(b) REGULATIONS.—The Secretary shall promul-
2 gate regulations to define the dependents to which cov-
3 erage shall be made available under subsection (a).
4 "(c) RULE OF CONSTRUCTION.—Nothing in this sec-
5 tion shall be construed to modify the definition of 'depend-
6 ent' as used in the Internal Revenue Code of 1986 with
7 respect to the tax treatment of the cost of coverage.

8 **"SEC. 2715. DEVELOPMENT AND UTILIZATION OF UNIFORM**
9 **EXPLANATION OF COVERAGE DOCUMENTS**
10 **AND STANDARDIZED DEFINITIONS.**

11 "(a) IN GENERAL.—Not later than 12 months after
12 the date of enactment of the Patient Protection and Af-
13 fordable Care Act, the Secretary shall develop standards
14 for use by a group health plan and a health insurance
15 issuer offering group or individual health insurance cov-
16 erage, in compiling and providing to enrollees a summary
17 of benefits and coverage explanation that accurately de-
18 scribes the benefits and coverage under the applicable plan
19 or coverage. In developing such standards, the Secretary
20 shall consult with the National Association of Insurance
21 Commissioners (referred to in this section as the 'NAIC'),
22 a working group composed of representatives of health in-
23 surance-related consumer advocacy organizations, health
24 insurance issuers, health care professionals, patient advo-

1 cates including those representing individuals with limited
2 English proficiency, and other qualified individuals.
3 "(b) REQUIREMENTS.—The standards for the sum-
4 mary of benefits and coverage developed under subsection
5 (a) shall provide for the following:
6 "(1) APPEARANCE.—The standards shall en-
7 sure that the summary of benefits and coverage is
8 presented in a uniform format that does not exceed
9 4 pages in length and does not include print smaller
10 than 12-point font.
11 "(2) LANGUAGE.—The standards shall ensure
12 that the summary is presented in a culturally and
13 linguistically appropriate manner and utilizes termi-
14 nology understandable by the average plan enrollee.
15 "(3) CONTENTS.—The standards shall ensure
16 that the summary of benefits and coverage in-
17 cludes—
18 "(A) uniform definitions of standard insur-
19 ance terms and medical terms (consistent with
20 subsection (g)) so that consumers may compare
21 health insurance coverage and understand the
22 terms of coverage (or exception to such cov-
23 erage);
24 "(B) a description of the coverage, includ-
25 ing cost sharing for—

"(i) each of the categories of the essential health benefits described in subparagraphs (A) through (J) of section 1302(b)(1) of the Patient Protection and Affordable Care Act; and

"(ii) other benefits, as identified by the Secretary;

"(C) the exceptions, reductions, and limitations on coverage;

"(D) the cost-sharing provisions, including deductible, coinsurance, and co-payment obligations;

"(E) the renewability and continuation of coverage provisions;

"(F) a coverage facts label that includes examples to illustrate common benefits scenarios, including pregnancy and serious or chronic medical conditions and related cost sharing, such scenarios to be based on recognized clinical practice guidelines;

"(G) a statement of whether the plan or coverage—

"(i) provides minimum essential coverage (as defined under section 5000A(f) of the Internal Revenue Code 1986); and

"(ii) ensures that the plan or coverage share of the total allowed costs of benefits provided under the plan or coverage is not less than 60 percent of such costs;

"(H) a statement that the outline is a summary of the policy or certificate and that the coverage document itself should be consulted to determine the governing contractual provisions; and

"(I) a contact number for the consumer to call with additional questions and an Internet web address where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained.

"(c) PERIODIC REVIEW AND UPDATING.—The Secretary shall periodically review and update, as appropriate, the standards developed under this section.

"(d) REQUIREMENT TO PROVIDE.—

"(1) IN GENERAL.—Not later than 24 months after the date of enactment of the Patient Protection and Affordable Care Act, each entity described in paragraph (3) shall provide, prior to any enrollment restriction, a summary of benefits and coverage explanation pursuant to the standards developed by the Secretary under subsection (a) to—

"(A) an applicant at the time of application;

"(B) an enrollee prior to the time of enrollment or reenrollment, as applicable; and

"(C) a policyholder or certificate holder at the time of issuance of the policy or delivery of the certificate.

"(2) COMPLIANCE.—An entity described in paragraph (3) is deemed to be in compliance with this section if the summary of benefits and coverage described in subsection (a) is provided in paper or electronic form.

"(3) ENTITIES IN GENERAL.—An entity described in this paragraph is—

"(A) a health insurance issuer (including a group health plan that is not a self-insured plan) offering health insurance coverage within the United States; or

"(B) in the case of a self-insured group health plan, the plan sponsor or designated administrator of the plan (as such terms are defined in section 3(16) of the Employee Retirement Income Security Act of 1974).

"(4) NOTICE OF MODIFICATIONS.—If a group health plan or health insurance issuer makes any

material modification in any of the terms of the plan or coverage involved (as defined for purposes of section 102 of the Employee Retirement Income Security Act of 1974) that is not reflected in the most recently provided summary of benefits and coverage, the plan or issuer shall provide notice of such modification to enrollees not later than 60 days prior to the date on which such modification will become effective.

"(e) PREEMPTION.—The standards developed under subsection (a) shall preempt any related State standards that require a summary of benefits and coverage that provides less information to consumers than that required to be provided under this section, as determined by the Secretary.

"(f) FAILURE TO PROVIDE.—An entity described in subsection (d)(3) that willfully fails to provide the information required under this section shall be subject to a fine of not more than $1,000 for each such failure. Such failure with respect to each enrollee shall constitute a separate offense for purposes of this subsection.

"(g) DEVELOPMENT OF STANDARD DEFINITIONS.—

"(1) IN GENERAL.—The Secretary shall, by regulation, provide for the development of standards for the definitions of terms used in health insurance

1 coverage, including the insurance-related terms de-
2 scribed in paragraph (2) and the medical terms de-
3 scribed in paragraph (3).

4 "(2) INSURANCE-RELATED TERMS.—The insur-
5 ance-related terms described in this paragraph are
6 premium, deductible, co-insurance, co-payment, out-
7 of-pocket limit, preferred provider, non-preferred
8 provider, out-of-network co-payments, UCR (usual,
9 customary and reasonable) fees, excluded services,
10 grievance and appeals, and such other terms as the
11 Secretary determines are important to define so that
12 consumers may compare health insurance coverage
13 and understand the terms of their coverage.

14 "(3) MEDICAL TERMS.—The medical terms de-
15 scribed in this paragraph are hospitalization, hos-
16 pital outpatient care, emergency room care, physi-
17 cian services, prescription drug coverage, durable
18 medical equipment, home health care, skilled nursing
19 care, rehabilitation services, hospice services, emer-
20 gency medical transportation, and such other terms
21 as the Secretary determines are important to define
22 so that consumers may compare the medical benefits
23 offered by health insurance and understand the ex-
24 tent of those medical benefits (or exceptions to those
25 benefits).

1 **"SEC. 2716. PROHIBITION OF DISCRIMINATION BASED ON**
2 **SALARY.**

3 "(a) IN GENERAL.—The plan sponsor of a group
4 health plan (other than a self-insured plan) may not estab-
5 lish rules relating to the health insurance coverage eligi-
6 bility (including continued eligibility) of any full-time em-
7 ployee under the terms of the plan that are based on the
8 total hourly or annual salary of the employee or otherwise
9 establish eligibility rules that have the effect of discrimi-
10 nating in favor of higher wage employees.

11 "(b) LIMITATION.—Subsection (a) shall not be con-
12 strued to prohibit a plan sponsor from establishing con-
13 tribution requirements for enrollment in the plan or cov-
14 erage that provide for the payment by employees with
15 lower hourly or annual compensation of a lower dollar or
16 percentage contribution than the payment required of
17 similarly situated employees with a higher hourly or an-
18 nual compensation.

19 **"SEC. 2717. ENSURING THE QUALITY OF CARE.**

20 "(a) QUALITY REPORTING.—

21 "(1) IN GENERAL.—Not later than 2 years
22 after the date of enactment of the Patient Protection
23 and Affordable Care Act, the Secretary, in consulta-
24 tion with experts in health care quality and stake-
25 holders, shall develop reporting requirements for use
26 by a group health plan, and a health insurance

issuer offering group or individual health insurance coverage, with respect to plan or coverage benefits and health care provider reimbursement structures that—

"(A) improve health outcomes through the implementation of activities such as quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives, including through the use of the medical homes model as defined for purposes of section 3602 of the Patient Protection and Affordable Care Act, for treatment or services under the plan or coverage;

"(B) implement activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional;

"(C) implement activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices,

1 evidence based medicine, and health informa-
2 tion technology under the plan or coverage; and
3 "(D) implement wellness and health pro-
4 motion activities.
5 "(2) REPORTING REQUIREMENTS.—
6 "(A) IN GENERAL.—A group health plan
7 and a health insurance issuer offering group or
8 individual health insurance coverage shall annu-
9 ally submit to the Secretary, and to enrollees
10 under the plan or coverage, a report on whether
11 the benefits under the plan or coverage satisfy
12 the elements described in subparagraphs (A)
13 through (D) of paragraph (1).
14 "(B) TIMING OF REPORTS.—A report
15 under subparagraph (A) shall be made available
16 to an enrollee under the plan or coverage dur-
17 ing each open enrollment period.
18 "(C) AVAILABILITY OF REPORTS.—The
19 Secretary shall make reports submitted under
20 subparagraph (A) available to the public
21 through an Internet website
22 "(D) PENALTIES.—In developing the re-
23 porting requirements under paragraph (1), the
24 Secretary may develop and impose appropriate

1 penalties for non-compliance with such require-
2 ments.
3 "(E) EXCEPTIONS.—In developing the re-
4 porting requirements under paragraph (1), the
5 Secretary may provide for exceptions to such
6 requirements for group health plans and health
7 insurance issuers that substantially meet the
8 goals of this section.
9 "(b) WELLNESS AND PREVENTION PROGRAMS.—For
10 purposes of subsection (a)(1)(D), wellness and health pro-
11 motion activities may include personalized wellness and
12 prevention services, which are coordinated, maintained or
13 delivered by a health care provider, a wellness and preven-
14 tion plan manager, or a health, wellness or prevention
15 services organization that conducts health risk assess-
16 ments or offers ongoing face-to-face, telephonic or web-
17 based intervention efforts for each of the program's par-
18 ticipants, and which may include the following wellness
19 and prevention efforts:
20 "(1) Smoking cessation.
21 "(2) Weight management.
22 "(3) Stress management.
23 "(4) Physical fitness.
24 "(5) Nutrition.
25 "(6) Heart disease prevention.

1 ''(7) Healthy lifestyle support.

2 ''(8) Diabetes prevention.

3 ''(c) REGULATIONS.—Not later than 2 years after the
4 date of enactment of the Patient Protection and Afford-
5 able Care Act, the Secretary shall promulgate regulations
6 that provide criteria for determining whether a reimburse-
7 ment structure is described in subsection (a).

8 ''(d) STUDY AND REPORT.—Not later than 180 days
9 after the date on which regulations are promulgated under
10 subsection (c), the Government Accountability Office shall
11 review such regulations and conduct a study and submit
12 to the Committee on Health, Education, Labor, and Pen-
13 sions of the Senate and the Committee on Energy and
14 Commerce of the House of Representatives a report re-
15 garding the impact the activities under this section have
16 had on the quality and cost of health care.

17 **''SEC. 2718. BRINGING DOWN THE COST OF HEALTH CARE**
18 **COVERAGE.**

19 ''(a) CLEAR ACCOUNTING FOR COSTS.—A health in-
20 surance issuer offering group or individual health insur-
21 ance coverage shall, with respect to each plan year, submit
22 to the Secretary a report concerning the percentage of
23 total premium revenue that such coverage expends—

24 ''(1) on reimbursement for clinical services pro-
25 vided to enrollees under such coverage;

1 "(2) for activities that improve health care
2 quality; and
3 "(3) on all other non-claims costs, including an
4 explanation of the nature of such costs, and exclud-
5 ing State taxes and licensing or regulatory fees.
6 The Secretary shall make reports received under this sec-
7 tion available to the public on the Internet website of the
8 Department of Health and Human Services.
9 "(b) ENSURING THAT CONSUMERS RECEIVE VALUE
10 FOR THEIR PREMIUM PAYMENTS.—
11 "(1) REQUIREMENT TO PROVIDE VALUE FOR
12 PREMIUM PAYMENTS.—A health insurance issuer of-
13 fering group or individual health insurance coverage
14 shall, with respect to each plan year, provide an an-
15 nual rebate to each enrollee under such coverage, on
16 a pro rata basis, in an amount that is equal to the
17 amount by which premium revenue expended by the
18 issuer on activities described in subsection (a)(3) ex-
19 ceeds—
20 "(A) with respect to a health insurance
21 issuer offering coverage in the group market,
22 20 percent, or such lower percentage as a State
23 may by regulation determine; or
24 "(B) with respect to a health insurance
25 issuer offering coverage in the individual mar-

ket, 25 percent, or such lower percentage as a State may by regulation determine, except that such percentage shall be adjusted to the extent the Secretary determines that the application of such percentage with a State may destabilize the existing individual market in such State.

"(2) CONSIDERATION IN SETTING PERCENTAGES.—In determining the percentages under paragraph (1), a State shall seek to ensure adequate participation by health insurance issuers, competition in the health insurance market in the State, and value for consumers so that premiums are used for clinical services and quality improvements.

"(3) TERMINATION.—The provisions of this subsection shall have no force or effect after December 31, 2013.

"(c) STANDARD HOSPITAL CHARGES.—Each hospital operating within the United States shall for each year establish (and update) and make public (in accordance with guidelines developed by the Secretary) a list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups established under section 1886(d)(4) of the Social Security Act.

1 "(d) DEFINITIONS.—The Secretary, in consultation
2 with the National Association of Insurance Commissions,
3 shall establish uniform definitions for the activities re-
4 ported under subsection (a).

5 **"SEC. 2719. APPEALS PROCESS.**

6 "A group health plan and a health insurance issuer
7 offering group or individual health insurance coverage
8 shall implement an effective appeals process for appeals
9 of coverage determinations and claims, under which the
10 plan or issuer shall, at a minimum—

11 "(1) have in effect an internal claims appeal
12 process;

13 "(2) provide notice to enrollees, in a culturally
14 and linguistically appropriate manner, of available
15 internal and external appeals processes, and the
16 availability of any applicable office of health insur-
17 ance consumer assistance or ombudsman established
18 under section 2793 to assist such enrollees with the
19 appeals processes;

20 "(3) allow an enrollee to review their file, to
21 present evidence and testimony as part of the ap-
22 peals process, and to receive continued coverage
23 pending the outcome of the appeals process; and

24 "(4) provide an external review process for such
25 plans and issuers that, at a minimum, includes the

consumer protections set forth in the Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners and is binding on such plans.''.

SEC. 1002. HEALTH INSURANCE CONSUMER INFORMATION.

Part C of title XXVII of the Public Health Service Act (42 U.S.C. 300gg-91 et seq.) is amended by adding at the end the following:

''SEC. 2793. HEALTH INSURANCE CONSUMER INFORMATION.

''(a) IN GENERAL.—The Secretary shall award grants to States to enable such States (or the Exchanges operating in such States) to establish, expand, or provide support for—

''(1) offices of health insurance consumer assistance; or

''(2) health insurance ombudsman programs.

''(b) ELIGIBILITY.—

''(1) IN GENERAL.—To be eligible to receive a grant, a State shall designate an independent office of health insurance consumer assistance, or an ombudsman, that, directly or in coordination with State health insurance regulators and consumer assistance organizations, receives and responds to inquiries and complaints concerning health insurance coverage

with respect to Federal health insurance requirements and under State law.

"(2) CRITERIA.—A State that receives a grant under this section shall comply with criteria established by the Secretary for carrying out activities under such grant.

"(c) DUTIES.—The office of health insurance consumer assistance or health insurance ombudsman shall—

"(1) assist with the filing of complaints and appeals, including filing appeals with the internal appeal or grievance process of the group health plan or health insurance issuer involved and providing information about the external appeal process;

"(2) collect, track, and quantify problems and inquiries encountered by consumers;

"(3) educate consumers on their rights and responsibilities with respect to group health plans and health insurance coverage;

"(4) assist consumers with enrollment in a group health plan or health insurance coverage by providing information, referral, and assistance; and

"(5) resolve problems with obtaining premium tax credits under section 36B of the Internal Revenue Code of 1986.

1 "(d) DATA COLLECTION.—As a condition of receiving
2 a grant under subsection (a), an office of health insurance
3 consumer assistance or ombudsman program shall be re-
4 quired to collect and report data to the Secretary on the
5 types of problems and inquiries encountered by con-
6 sumers. The Secretary shall utilize such data to identify
7 areas where more enforcement action is necessary and
8 shall share such information with State insurance regu-
9 lators, the Secretary of Labor, and the Secretary of the
10 Treasury for use in the enforcement activities of such
11 agencies.

12 "(e) FUNDING.—

13 "(1) INITIAL FUNDING.—There is hereby ap-
14 propriated to the Secretary, out of any funds in the
15 Treasury not otherwise appropriated, $30,000,000
16 for the first fiscal year for which this section applies
17 to carry out this section. Such amount shall remain
18 available without fiscal year limitation.

19 "(2) AUTHORIZATION FOR SUBSEQUENT
20 YEARS.—There is authorized to be appropriated to
21 the Secretary for each fiscal year following the fiscal
22 year described in paragraph (1), such sums as may
23 be necessary to carry out this section.".

SEC. 1003. ENSURING THAT CONSUMERS GET VALUE FOR THEIR DOLLARS.

Part C of title XXVII of the Public Health Service Act (42 U.S.C. 300gg-91 et seq.), as amended by section 1002, is further amended by adding at the end the following:

"SEC. 2794. ENSURING THAT CONSUMERS GET VALUE FOR THEIR DOLLARS.

"(a) INITIAL PREMIUM REVIEW PROCESS.—

"(1) IN GENERAL.—The Secretary, in conjunction with States, shall establish a process for the annual review, beginning with the 2010 plan year and subject to subsection (b)(2)(A), of unreasonable increases in premiums for health insurance coverage.

"(2) JUSTIFICATION AND DISCLOSURE.—The process established under paragraph (1) shall require health insurance issuers to submit to the Secretary and the relevant State a justification for an unreasonable premium increase prior to the implementation of the increase. Such issuers shall prominently post such information on their Internet websites. The Secretary shall ensure the public disclosure of information on such increases and justifications for all health insurance issuers.

"(b) CONTINUING PREMIUM REVIEW PROCESS.—

1 "(1) INFORMING SECRETARY OF PREMIUM IN-
2 CREASE PATTERNS.—As a condition of receiving a
3 grant under subsection (c)(1), a State, through its
4 Commissioner of Insurance, shall—
5 "(A) provide the Secretary with informa-
6 tion about trends in premium increases in
7 health insurance coverage in premium rating
8 areas in the State; and
9 "(B) make recommendations, as appro-
10 priate, to the State Exchange about whether
11 particular health insurance issuers should be
12 excluded from participation in the Exchange
13 based on a pattern or practice of excessive or
14 unjustified premium increases.
15 "(2) MONITORING BY SECRETARY OF PREMIUM
16 INCREASES.—
17 "(A) IN GENERAL.—Beginning with plan
18 years beginning in 2014, the Secretary, in con-
19 junction with the States and consistent with the
20 provisions of subsection (a)(2), shall monitor
21 premium increases of health insurance coverage
22 offered through an Exchange and outside of an
23 Exchange.
24 "(B) CONSIDERATION IN OPENING EX-
25 CHANGE.—In determining under section

1312(f)(2)(B) of the Patient Protection and Affordable Care Act whether to offer qualified health plans in the large group market through an Exchange, the State shall take into account any excess of premium growth outside of the Exchange as compared to the rate of such growth inside the Exchange.

"(c) GRANTS IN SUPPORT OF PROCESS.—

"(1) PREMIUM REVIEW GRANTS DURING 2010 THROUGH 2014.—The Secretary shall carry out a program to award grants to States during the 5-year period beginning with fiscal year 2010 to assist such States in carrying out subsection (a), including—

"(A) in reviewing and, if appropriate under State law, approving premium increases for health insurance coverage; and

"(B) in providing information and recommendations to the Secretary under subsection (b)(1).

"(2) FUNDING.—

"(A) IN GENERAL.—Out of all funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary $250,000,000, to be available for expenditure for grants under paragraph (1) and subparagraph (B).

"(B) FURTHER AVAILABILITY FOR INSURANCE REFORM AND CONSUMER PROTECTION.—If the amounts appropriated under subparagraph (A) are not fully obligated under grants under paragraph (1) by the end of fiscal year 2014, any remaining funds shall remain available to the Secretary for grants to States for planning and implementing the insurance reforms and consumer protections under part A.

"(C) ALLOCATION.—The Secretary shall establish a formula for determining the amount of any grant to a State under this subsection. Under such formula—

"(i) the Secretary shall consider the number of plans of health insurance coverage offered in each State and the population of the State; and

"(ii) no State qualifying for a grant under paragraph (1) shall receive less than $1,000,000, or more than $5,000,000 for a grant year.".

SEC. 1004. EFFECTIVE DATES.

(a) IN GENERAL.—Except as provided for in subsection (b), this subtitle (and the amendments made by this subtitle) shall become effective for plan years begin-

ning on or after the date that is 6 months after the date of enactment of this Act, except that the amendments made by sections 1002 and 1003 shall become effective for fiscal years beginning with fiscal year 2010.

(b) SPECIAL RULE.—The amendments made by sections 1002 and 1003 shall take effect on the date of enactment of this Act.

Subtitle B—Immediate Actions to Preserve and Expand Coverage

SEC. 1101. IMMEDIATE ACCESS TO INSURANCE FOR UNINSURED INDIVIDUALS WITH A PREEXISTING CONDITION.

(a) IN GENERAL.—Not later than 90 days after the date of enactment of this Act, the Secretary shall establish a temporary high risk health insurance pool program to provide health insurance coverage for eligible individuals during the period beginning on the date on which such program is established and ending on January 1, 2014.

(b) ADMINISTRATION.—

(1) IN GENERAL.—The Secretary may carry out the program under this section directly or through contracts to eligible entities.

(2) ELIGIBLE ENTITIES.—To be eligible for a contract under paragraph (1), an entity shall—

(A) be a State or nonprofit private entity;

(B) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require; and

(C) agree to utilize contract funding to establish and administer a qualified high risk pool for eligible individuals.

(3) MAINTENANCE OF EFFORT.—To be eligible to enter into a contract with the Secretary under this subsection, a State shall agree not to reduce the annual amount the State expended for the operation of one or more State high risk pools during the year preceding the year in which such contract is entered into.

(c) QUALIFIED HIGH RISK POOL.—

(1) IN GENERAL.—Amounts made available under this section shall be used to establish a qualified high risk pool that meets the requirements of paragraph (2).

(2) REQUIREMENTS.—A qualified high risk pool meets the requirements of this paragraph if such pool—

(A) provides to all eligible individuals health insurance coverage that does not impose

1 any preexisting condition exclusion with respect
2 to such coverage;
3 (B) provides health insurance coverage—
4 (i) in which the issuer's share of the
5 total allowed costs of benefits provided
6 under such coverage is not less than 65
7 percent of such costs; and
8 (ii) that has an out of pocket limit not
9 greater than the applicable amount de-
10 scribed in section 223(c)(2) of the Internal
11 Revenue Code of 1986 for the year in-
12 volved, except that the Secretary may mod-
13 ify such limit if necessary to ensure the
14 pool meets the actuarial value limit under
15 clause (i);
16 (C) ensures that with respect to the pre-
17 mium rate charged for health insurance cov-
18 erage offered to eligible individuals through the
19 high risk pool, such rate shall—
20 (i) except as provided in clause (ii),
21 vary only as provided for under section
22 2701 of the Public Health Service Act (as
23 amended by this Act and notwithstanding
24 the date on which such amendments take
25 effect);

(ii) vary on the basis of age by a factor of not greater than 4 to 1; and

(iii) be established at a standard rate for a standard population; and

(D) meets any other requirements determined appropriate by the Secretary.

(d) ELIGIBLE INDIVIDUAL.—An individual shall be deemed to be an eligible individual for purposes of this section if such individual—

(1) is a citizen or national of the United States or is lawfully present in the United States (as determined in accordance with section 1411);

(2) has not been covered under creditable coverage (as defined in section 2701(c)(1) of the Public Health Service Act as in effect on the date of enactment of this Act) during the 6-month period prior to the date on which such individual is applying for coverage through the high risk pool; and

(3) has a pre-existing condition, as determined in a manner consistent with guidance issued by the Secretary.

(e) PROTECTION AGAINST DUMPING RISK BY INSURERS.—

(1) IN GENERAL.—The Secretary shall establish criteria for determining whether health insurance

1 issuers and employment-based health plans have dis-
2 couraged an individual from remaining enrolled in
3 prior coverage based on that individual's health sta-
4 tus.

5 (2) SANCTIONS.—An issuer or employment-
6 based health plan shall be responsible for reimburs-
7 ing the program under this section for the medical
8 expenses incurred by the program for an individual
9 who, based on criteria established by the Secretary,
10 the Secretary finds was encouraged by the issuer to
11 disenroll from health benefits coverage prior to en-
12 rolling in coverage through the program. The cri-
13 teria shall include at least the following cir-
14 cumstances:

15 (A) In the case of prior coverage obtained
16 through an employer, the provision by the em-
17 ployer, group health plan, or the issuer of
18 money or other financial consideration for
19 disenrolling from the coverage.

20 (B) In the case of prior coverage obtained
21 directly from an issuer or under an employ-
22 ment-based health plan—

23 (i) the provision by the issuer or plan
24 of money or other financial consideration
25 for disenrolling from the coverage; or

(ii) in the case of an individual whose premium for the prior coverage exceeded the premium required by the program (adjusted based on the age factors applied to the prior coverage)—

(I) the prior coverage is a policy that is no longer being actively marketed (as defined by the Secretary) by the issuer; or

(II) the prior coverage is a policy for which duration of coverage form issue or health status are factors that can be considered in determining premiums at renewal.

(3) CONSTRUCTION.—Nothing in this subsection shall be construed as constituting exclusive remedies for violations of criteria established under paragraph (1) or as preventing States from applying or enforcing such paragraph or other provisions under law with respect to health insurance issuers.

(f) OVERSIGHT.—The Secretary shall establish—

(1) an appeals process to enable individuals to appeal a determination under this section; and

(2) procedures to protect against waste, fraud, and abuse.

1 (g) FUNDING; TERMINATION OF AUTHORITY.—

2 (1) IN GENERAL.—There is appropriated to the
3 Secretary, out of any moneys in the Treasury not
4 otherwise appropriated, $5,000,000,000 to pay
5 claims against (and the administrative costs of) the
6 high risk pool under this section that are in excess
7 of the amount of premiums collected from eligible in-
8 dividuals enrolled in the high risk pool. Such funds
9 shall be available without fiscal year limitation.

10 (2) INSUFFICIENT FUNDS.—If the Secretary es-
11 timates for any fiscal year that the aggregate
12 amounts available for the payment of the expenses
13 of the high risk pool will be less than the actual
14 amount of such expenses, the Secretary shall make
15 such adjustments as are necessary to eliminate such
16 deficit.

17 (3) TERMINATION OF AUTHORITY.—

18 (A) IN GENERAL.—Except as provided in
19 subparagraph (B), coverage of eligible individ-
20 uals under a high risk pool in a State shall ter-
21 minate on January 1, 2014.

22 (B) TRANSITION TO EXCHANGE.—The
23 Secretary shall develop procedures to provide
24 for the transition of eligible individuals enrolled
25 in health insurance coverage offered through a

high risk pool established under this section into qualified health plans offered through an Exchange. Such procedures shall ensure that there is no lapse in coverage with respect to the individual and may extend coverage after the termination of the risk pool involved, if the Secretary determines necessary to avoid such a lapse.

(4) LIMITATIONS.—The Secretary has the authority to stop taking applications for participation in the program under this section to comply with the funding limitation provided for in paragraph (1).

(5) RELATION TO STATE LAWS.—The standards established under this section shall supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency) with respect to qualified high risk pools which are established in accordance with this section.

SEC. 1102. REINSURANCE FOR EARLY RETIREES.

(a) ADMINISTRATION.—

(1) IN GENERAL.—Not later than 90 days after the date of enactment of this Act, the Secretary shall establish a temporary reinsurance program to provide reimbursement to participating employment-based plans for a portion of the cost of providing

1 health insurance coverage to early retirees (and to
2 the eligible spouses, surviving spouses, and depend-
3 ents of such retirees) during the period beginning on
4 the date on which such program is established and
5 ending on January 1, 2014.
6 (2) REFERENCE.—In this section:
7 (A) HEALTH BENEFITS.—The term
8 ''health benefits'' means medical, surgical, hos-
9 pital, prescription drug, and such other benefits
10 as shall be determined by the Secretary, wheth-
11 er self-funded, or delivered through the pur-
12 chase of insurance or otherwise.
13 (B) EMPLOYMENT-BASED PLAN.—The
14 term ''employment-based plan'' means a group
15 health benefits plan that—
16 (i) is—
17 (I) maintained by one or more
18 current or former employers (includ-
19 ing without limitation any State or
20 local government or political subdivi-
21 sion thereof), employee organization, a
22 voluntary employees' beneficiary asso-
23 ciation, or a committee or board of in-
24 dividuals appointed to administer such
25 plan; or

(II) a multiemployer plan (as defined in section 3(37) of the Employee Retirement Income Security Act of 1974); and

(ii) provides health benefits to early retirees.

(C) EARLY RETIREES.—The term ''early retirees'' means individuals who are age 55 and older but are not eligible for coverage under title XVIII of the Social Security Act, and who are not active employees of an employer maintaining, or currently contributing to, the employment-based plan or of any employer that has made substantial contributions to fund such plan.

(b) PARTICIPATION.—

(1) EMPLOYMENT-BASED PLAN ELIGIBILITY.—A participating employment-based plan is an employment-based plan that—

(A) meets the requirements of paragraph (2) with respect to health benefits provided under the plan; and

(B) submits to the Secretary an application for participation in the program, at such

time, in such manner, and containing such information as the Secretary shall require.

(2) EMPLOYMENT-BASED HEALTH BENEFITS.—An employment-based plan meets the requirements of this paragraph if the plan—

(A) implements programs and procedures to generate cost-savings with respect to participants with chronic and high-cost conditions;

(B) provides documentation of the actual cost of medical claims involved; and

(C) is certified by the Secretary.

(c) PAYMENTS.—

(1) SUBMISSION OF CLAIMS.—

(A) IN GENERAL.—A participating employment-based plan shall submit claims for reimbursement to the Secretary which shall contain documentation of the actual costs of the items and services for which each claim is being submitted.

(B) BASIS FOR CLAIMS.—Claims submitted under subparagraph (A) shall be based on the actual amount expended by the participating employment-based plan involved within the plan year for the health benefits provided to an early retiree or the spouse, surviving spouse, or de-

pendent of such retiree. In determining the amount of a claim for purposes of this subsection, the participating employment-based plan shall take into account any negotiated price concessions (such as discounts, direct or indirect subsidies, rebates, and direct or indirect remunerations) obtained by such plan with respect to such health benefit. For purposes of determining the amount of any such claim, the costs paid by the early retiree or the retiree's spouse, surviving spouse, or dependent in the form of deductibles, co-payments, or co-insurance shall be included in the amounts paid by the participating employment-based plan.

(2) PROGRAM PAYMENTS.—If the Secretary determines that a participating employment-based plan has submitted a valid claim under paragraph (1), the Secretary shall reimburse such plan for 80 percent of that portion of the costs attributable to such claim that exceed $15,000, subject to the limits contained in paragraph (3).

(3) LIMIT.—To be eligible for reimbursement under the program, a claim submitted by a participating employment-based plan shall not be less than $15,000 nor greater than $90,000. Such amounts

shall be adjusted each fiscal year based on the percentage increase in the Medical Care Component of the Consumer Price Index for all urban consumers (rounded to the nearest multiple of $1,000) for the year involved.

(4) USE OF PAYMENTS.—Amounts paid to a participating employment-based plan under this subsection shall be used to lower costs for the plan. Such payments may be used to reduce premium costs for an entity described in subsection (a)(2)(B)(i) or to reduce premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs for plan participants. Such payments shall not be used as general revenues for an entity described in subsection (a)(2)(B)(i). The Secretary shall develop a mechanism to monitor the appropriate use of such payments by such entities.

(5) PAYMENTS NOT TREATED AS INCOME.—Payments received under this subsection shall not be included in determining the gross income of an entity described in subsection (a)(2)(B)(i) that is maintaining or currently contributing to a participating employment-based plan.

(6) APPEALS.—The Secretary shall establish—

(A) an appeals process to permit participating employment-based plans to appeal a determination of the Secretary with respect to claims submitted under this section; and

(B) procedures to protect against fraud, waste, and abuse under the program.

(d) AUDITS.—The Secretary shall conduct annual audits of claims data submitted by participating employment-based plans under this section to ensure that such plans are in compliance with the requirements of this section.

(e) FUNDING.—There is appropriated to the Secretary, out of any moneys in the Treasury not otherwise appropriated, $5,000,000,000 to carry out the program under this section. Such funds shall be available without fiscal year limitation.

(f) LIMITATION.—The Secretary has the authority to stop taking applications for participation in the program based on the availability of funding under subsection (e).

SEC. 1103. IMMEDIATE INFORMATION THAT ALLOWS CONSUMERS TO IDENTIFY AFFORDABLE COVERAGE OPTIONS.

(a) INTERNET PORTAL TO AFFORDABLE COVERAGE OPTIONS.—

1 (1) IMMEDIATE ESTABLISHMENT.—Not later
2 than July 1, 2010, the Secretary, in consultation
3 with the States, shall establish a mechanism, includ-
4 ing an Internet website, through which a resident of
5 any State may identify affordable health insurance
6 coverage options in that State.
7 (2) CONNECTING TO AFFORDABLE COV-
8 ERAGE.—An Internet website established under
9 paragraph (1) shall, to the extent practicable, pro-
10 vide ways for residents of any State to receive infor-
11 mation on at least the following coverage options:
12 (A) Health insurance coverage offered by
13 health insurance issuers, other than coverage
14 that provides reimbursement only for the treat-
15 ment or mitigation of—
16 (i) a single disease or condition; or
17 (ii) an unreasonably limited set of dis-
18 eases or conditions (as determined by the
19 Secretary);
20 (B) Medicaid coverage under title XIX of
21 the Social Security Act.
22 (C) Coverage under title XXI of the Social
23 Security Act.

(D) A State health benefits high risk pool, to the extent that such high risk pool is offered in such State; and

(E) Coverage under a high risk pool under section 1101.

(b) ENHANCING COMPARATIVE PURCHASING OPTIONS.—

(1) IN GENERAL.—Not later than 60 days after the date of enactment of this Act, the Secretary shall develop a standardized format to be used for the presentation of information relating to the coverage options described in subsection (a)(2). Such format shall, at a minimum, require the inclusion of information on the percentage of total premium revenue expended on nonclinical costs (as reported under section 2718(a) of the Public Health Service Act), eligibility, availability, premium rates, and cost sharing with respect to such coverage options and be consistent with the standards adopted for the uniform explanation of coverage as provided for in section 2715 of the Public Health Service Act.

(2) USE OF FORMAT.—The Secretary shall utilize the format developed under paragraph (1) in compiling information concerning coverage options

on the Internet website established under subsection (a).

(c) AUTHORITY TO CONTRACT.—The Secretary may carry out this section through contracts entered into with qualified entities.

SEC. 1104. ADMINISTRATIVE SIMPLIFICATION.

(a) PURPOSE OF ADMINISTRATIVE SIMPLIFICATION.—Section 261 of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d note) is amended—

(1) by inserting ''uniform'' before ''standards''; and

(2) by inserting ''and to reduce the clerical burden on patients, health care providers, and health plans'' before the period at the end.

(b) OPERATING RULES FOR HEALTH INFORMATION TRANSACTIONS.—

(1) DEFINITION OF OPERATING RULES.—Section 1171 of the Social Security Act (42 U.S.C. 1320d) is amended by adding at the end the following:

''(9) OPERATING RULES.—The term 'operating rules' means the necessary business rules and guidelines for the electronic exchange of information that

are not defined by a standard or its implementation specifications as adopted for purposes of this part.''.

(2) TRANSACTION STANDARDS; OPERATING RULES AND COMPLIANCE.—Section 1173 of the Social Security Act (42 U.S.C. 1320d–2) is amended—

(A) in subsection (a)(2), by adding at the end the following new subparagraph:

''(J) Electronic funds transfers.'';

(B) in subsection (a), by adding at the end the following new paragraph:

''(4) REQUIREMENTS FOR FINANCIAL AND ADMINISTRATIVE TRANSACTIONS.—

''(A) IN GENERAL.—The standards and associated operating rules adopted by the Secretary shall—

''(i) to the extent feasible and appropriate, enable determination of an individual's eligibility and financial responsibility for specific services prior to or at the point of care;

''(ii) be comprehensive, requiring minimal augmentation by paper or other communications;

''(iii) provide for timely acknowledgment, response, and status reporting that

supports a transparent claims and denial management process (including adjudication and appeals); and

"(iv) describe all data elements (including reason and remark codes) in unambiguous terms, require that such data elements be required or conditioned upon set values in other fields, and prohibit additional conditions (except where necessary to implement State or Federal law, or to protect against fraud and abuse).

"(B) REDUCTION OF CLERICAL BURDEN.—In adopting standards and operating rules for the transactions referred to under paragraph (1), the Secretary shall seek to reduce the number and complexity of forms (including paper and electronic forms) and data entry required by patients and providers."; and

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

"(g) OPERATING RULES.—

"(1) IN GENERAL.—The Secretary shall adopt a single set of operating rules for each transaction referred to under subsection (a)(1) with the goal of creating as much uniformity in the implementation

of the electronic standards as possible. Such operating rules shall be consensus-based and reflect the necessary business rules affecting health plans and health care providers and the manner in which they operate pursuant to standards issued under Health Insurance Portability and Accountability Act of 1996.

"(2) OPERATING RULES DEVELOPMENT.—In adopting operating rules under this subsection, the Secretary shall consider recommendations for operating rules developed by a qualified nonprofit entity that meets the following requirements:

"(A) The entity focuses its mission on administrative simplification.

"(B) The entity demonstrates a multi-stakeholder and consensus-based process for development of operating rules, including representation by or participation from health plans, health care providers, vendors, relevant Federal agencies, and other standard development organizations.

"(C) The entity has a public set of guiding principles that ensure the operating rules and process are open and transparent, and supports nondiscrimination and conflict of interest poli-

1 cies that demonstrate a commitment to open,
2 fair, and nondiscriminatory practices.
3 "(D) The entity builds on the transaction
4 standards issued under Health Insurance Port-
5 ability and Accountability Act of 1996.
6 "(E) The entity allows for public review
7 and updates of the operating rules.
8 "(3) REVIEW AND RECOMMENDATIONS.—The
9 National Committee on Vital and Health Statistics
10 shall—
11 "(A) advise the Secretary as to whether a
12 nonprofit entity meets the requirements under
13 paragraph (2);
14 "(B) review the operating rules developed
15 and recommended by such nonprofit entity;
16 "(C) determine whether such operating
17 rules represent a consensus view of the health
18 care stakeholders and are consistent with and
19 do not conflict with other existing standards;
20 "(D) evaluate whether such operating rules
21 are consistent with electronic standards adopted
22 for health information technology; and
23 "(E) submit to the Secretary a rec-
24 ommendation as to whether the Secretary
25 should adopt such operating rules.

1 "(4) IMPLEMENTATION.—

2 "(A) IN GENERAL.—The Secretary shall
3 adopt operating rules under this subsection, by
4 regulation in accordance with subparagraph
5 (C), following consideration of the operating
6 rules developed by the non-profit entity de-
7 scribed in paragraph (2) and the recommenda-
8 tion submitted by the National Committee on
9 Vital and Health Statistics under paragraph
10 (3)(E) and having ensured consultation with
11 providers.

12 "(B) ADOPTION REQUIREMENTS; EFFEC-
13 TIVE DATES.—

14 "(i) ELIGIBILITY FOR A HEALTH
15 PLAN AND HEALTH CLAIM STATUS.—The
16 set of operating rules for eligibility for a
17 health plan and health claim status trans-
18 actions shall be adopted not later than
19 July 1, 2011, in a manner ensuring that
20 such operating rules are effective not later
21 than January 1, 2013, and may allow for
22 the use of a machine readable identifica-
23 tion card.

24 "(ii) ELECTRONIC FUNDS TRANSFERS
25 AND HEALTH CARE PAYMENT AND REMIT-

1 TANCE ADVICE.—The set of operating
2 rules for electronic funds transfers and
3 health care payment and remittance advice
4 transactions shall—
5 ''(I) allow for automated rec-
6 onciliation of the electronic payment
7 with the remittance advice; and
8 ''(II) be adopted not later than
9 July 1, 2012, in a manner ensuring
10 that such operating rules are effective
11 not later than January 1, 2014.
12 ''(iii) HEALTH CLAIMS OR EQUIVA-
13 LENT ENCOUNTER INFORMATION, ENROLL-
14 MENT AND DISENROLLMENT IN A HEALTH
15 PLAN, HEALTH PLAN PREMIUM PAYMENTS,
16 REFERRAL CERTIFICATION AND AUTHOR-
17 IZATION.—The set of operating rules for
18 health claims or equivalent encounter in-
19 formation, enrollment and disenrollment in
20 a health plan, health plan premium pay-
21 ments, and referral certification and au-
22 thorization transactions shall be adopted
23 not later than July 1, 2014, in a manner
24 ensuring that such operating rules are ef-
25 fective not later than January 1, 2016.

1 "(C) EXPEDITED RULEMAKING.—The Sec-
2 retary shall promulgate an interim final rule
3 applying any standard or operating rule rec-
4 ommended by the National Committee on Vital
5 and Health Statistics pursuant to paragraph
6 (3). The Secretary shall accept and consider
7 public comments on any interim final rule pub-
8 lished under this subparagraph for 60 days
9 after the date of such publication.
10 "(h) COMPLIANCE.—
11 "(1) HEALTH PLAN CERTIFICATION.—
12 "(A) ELIGIBILITY FOR A HEALTH PLAN,
13 HEALTH CLAIM STATUS, ELECTRONIC FUNDS
14 TRANSFERS, HEALTH CARE PAYMENT AND RE-
15 MITTANCE ADVICE.—Not later than December
16 31, 2013, a health plan shall file a statement
17 with the Secretary, in such form as the Sec-
18 retary may require, certifying that the data and
19 information systems for such plan are in com-
20 pliance with any applicable standards (as de-
21 scribed under paragraph (7) of section 1171)
22 and associated operating rules (as described
23 under paragraph (9) of such section) for elec-
24 tronic funds transfers, eligibility for a health

1 plan, health claim status, and health care pay-
2 ment and remittance advice, respectively.
3 "(B) HEALTH CLAIMS OR EQUIVALENT
4 ENCOUNTER INFORMATION, ENROLLMENT AND
5 DISENROLLMENT IN A HEALTH PLAN, HEALTH
6 PLAN PREMIUM PAYMENTS, HEALTH CLAIMS
7 ATTACHMENTS, REFERRAL CERTIFICATION AND
8 AUTHORIZATION.—Not later than December 31,
9 2015, a health plan shall file a statement with
10 the Secretary, in such form as the Secretary
11 may require, certifying that the data and infor-
12 mation systems for such plan are in compliance
13 with any applicable standards and associated
14 operating rules for health claims or equivalent
15 encounter information, enrollment and
16 disenrollment in a health plan, health plan pre-
17 mium payments, health claims attachments,
18 and referral certification and authorization, re-
19 spectively. A health plan shall provide the same
20 level of documentation to certify compliance
21 with such transactions as is required to certify
22 compliance with the transactions specified in
23 subparagraph (A).
24 "(2) DOCUMENTATION OF COMPLIANCE.—A
25 health plan shall provide the Secretary, in such form

as the Secretary may require, with adequate documentation of compliance with the standards and operating rules described under paragraph (1). A health plan shall not be considered to have provided adequate documentation and shall not be certified as being in compliance with such standards, unless the health plan—

"(A) demonstrates to the Secretary that the plan conducts the electronic transactions specified in paragraph (1) in a manner that fully complies with the regulations of the Secretary; and

"(B) provides documentation showing that the plan has completed end-to-end testing for such transactions with their partners, such as hospitals and physicians.

"(3) SERVICE CONTRACTS.—A health plan shall be required to ensure that any entities that provide services pursuant to a contract with such health plan shall comply with any applicable certification and compliance requirements (and provide the Secretary with adequate documentation of such compliance) under this subsection.

"(4) CERTIFICATION BY OUTSIDE ENTITY.—The Secretary may designate independent, outside

entities to certify that a health plan has complied with the requirements under this subsection, provided that the certification standards employed by such entities are in accordance with any standards or operating rules issued by the Secretary.

"(5) COMPLIANCE WITH REVISED STANDARDS AND OPERATING RULES.—

"(A) IN GENERAL.—A health plan (including entities described under paragraph (3)) shall file a statement with the Secretary, in such form as the Secretary may require, certifying that the data and information systems for such plan are in compliance with any applicable revised standards and associated operating rules under this subsection for any interim final rule promulgated by the Secretary under subsection (i) that—

"(i) amends any standard or operating rule described under paragraph (1) of this subsection; or

"(ii) establishes a standard (as described under subsection (a)(1)(B)) or associated operating rules (as described under subsection (i)(5)) for any other financial and administrative transactions.

1 "(B) DATE OF COMPLIANCE.—A health
2 plan shall comply with such requirements not
3 later than the effective date of the applicable
4 standard or operating rule.
5 "(6) AUDITS OF HEALTH PLANS.—The Sec-
6 retary shall conduct periodic audits to ensure that
7 health plans (including entities described under
8 paragraph (3)) are in compliance with any standards
9 and operating rules that are described under para-
10 graph (1) or subsection (i)(5).
11 "(i) REVIEW AND AMENDMENT OF STANDARDS AND
12 OPERATING RULES.—
13 "(1) ESTABLISHMENT.—Not later than Janu-
14 ary 1, 2014, the Secretary shall establish a review
15 committee (as described under paragraph (4)).
16 "(2) EVALUATIONS AND REPORTS.—
17 "(A) HEARINGS.—Not later than April 1,
18 2014, and not less than biennially thereafter,
19 the Secretary, acting through the review com-
20 mittee, shall conduct hearings to evaluate and
21 review the adopted standards and operating
22 rules established under this section.
23 "(B) REPORT.—Not later than July 1,
24 2014, and not less than biennially thereafter,
25 the review committee shall provide rec-

ommendations for updating and improving such standards and operating rules. The review committee shall recommend a single set of operating rules per transaction standard and maintain the goal of creating as much uniformity as possible in the implementation of the electronic standards.

"(3) INTERIM FINAL RULEMAKING.—

"(A) IN GENERAL.—Any recommendations to amend adopted standards and operating rules that have been approved by the review committee and reported to the Secretary under paragraph (2)(B) shall be adopted by the Secretary through promulgation of an interim final rule not later than 90 days after receipt of the committee's report.

"(B) PUBLIC COMMENT.—

"(i) PUBLIC COMMENT PERIOD.—The Secretary shall accept and consider public comments on any interim final rule published under this paragraph for 60 days after the date of such publication.

"(ii) EFFECTIVE DATE.—The effective date of any amendment to existing standards or operating rules that is adopted

through an interim final rule published under this paragraph shall be 25 months following the close of such public comment period.

"(4) REVIEW COMMITTEE.—

"(A) DEFINITION.—For the purposes of this subsection, the term 'review committee' means a committee chartered by or within the Department of Health and Human services that has been designated by the Secretary to carry out this subsection, including—

"(i) the National Committee on Vital and Health Statistics; or

"(ii) any appropriate committee as determined by the Secretary.

"(B) COORDINATION OF HIT STANDARDS.—In developing recommendations under this subsection, the review committee shall ensure coordination, as appropriate, with the standards that support the certified electronic health record technology approved by the Office of the National Coordinator for Health Information Technology.

"(5) OPERATING RULES FOR OTHER STANDARDS ADOPTED BY THE SECRETARY.—The Secretary

shall adopt a single set of operating rules (pursuant to the process described under subsection (g)) for any transaction for which a standard had been adopted pursuant to subsection (a)(1)(B).

"(j) PENALTIES.—

"(1) PENALTY FEE.—

"(A) IN GENERAL.—Not later than April 1, 2014, and annually thereafter, the Secretary shall assess a penalty fee (as determined under subparagraph (B)) against a health plan that has failed to meet the requirements under subsection (h) with respect to certification and documentation of compliance with—

"(i) the standards and associated operating rules described under paragraph (1) of such subsection; and

"(ii) a standard (as described under subsection (a)(1)(B)) and associated operating rules (as described under subsection (i)(5)) for any other financial and administrative transactions.

"(B) FEE AMOUNT.—Subject to subparagraphs (C), (D), and (E), the Secretary shall assess a penalty fee against a health plan in the amount of $1 per covered life until certification

is complete. The penalty shall be assessed per person covered by the plan for which its data systems for major medical policies are not in compliance and shall be imposed against the health plan for each day that the plan is not in compliance with the requirements under subsection (h).

"(C) ADDITIONAL PENALTY FOR MISREPRESENTATION.—A health plan that knowingly provides inaccurate or incomplete information in a statement of certification or documentation of compliance under subsection (h) shall be subject to a penalty fee that is double the amount that would otherwise be imposed under this subsection.

"(D) ANNUAL FEE INCREASE.—The amount of the penalty fee imposed under this subsection shall be increased on an annual basis by the annual percentage increase in total national health care expenditures, as determined by the Secretary.

"(E) PENALTY LIMIT.—A penalty fee assessed against a health plan under this subsection shall not exceed, on an annual basis—

"(i) an amount equal to $20 per covered life under such plan; or

"(ii) an amount equal to $40 per covered life under the plan if such plan has knowingly provided inaccurate or incomplete information (as described under subparagraph (C)).

"(F) DETERMINATION OF COVERED INDIVIDUALS.—The Secretary shall determine the number of covered lives under a health plan based upon the most recent statements and filings that have been submitted by such plan to the Securities and Exchange Commission.

"(2) NOTICE AND DISPUTE PROCEDURE.—The Secretary shall establish a procedure for assessment of penalty fees under this subsection that provides a health plan with reasonable notice and a dispute resolution procedure prior to provision of a notice of assessment by the Secretary of the Treasury (as described under paragraph (4)(B)).

"(3) PENALTY FEE REPORT.—Not later than May 1, 2014, and annually thereafter, the Secretary shall provide the Secretary of the Treasury with a report identifying those health plans that have been assessed a penalty fee under this subsection.

"(4) COLLECTION OF PENALTY FEE.—

"(A) IN GENERAL.—The Secretary of the Treasury, acting through the Financial Management Service, shall administer the collection of penalty fees from health plans that have been identified by the Secretary in the penalty fee report provided under paragraph (3).

"(B) NOTICE.—Not later than August 1, 2014, and annually thereafter, the Secretary of the Treasury shall provide notice to each health plan that has been assessed a penalty fee by the Secretary under this subsection. Such notice shall include the amount of the penalty fee assessed by the Secretary and the due date for payment of such fee to the Secretary of the Treasury (as described in subparagraph (C)).

"(C) PAYMENT DUE DATE.—Payment by a health plan for a penalty fee assessed under this subsection shall be made to the Secretary of the Treasury not later than November 1, 2014, and annually thereafter.

"(D) UNPAID PENALTY FEES.—Any amount of a penalty fee assessed against a health plan under this subsection for which pay-

ment has not been made by the due date provided under subparagraph (C) shall be—

"(i) increased by the interest accrued on such amount, as determined pursuant to the underpayment rate established under section 6621 of the Internal Revenue Code of 1986; and

"(ii) treated as a past-due, legally enforceable debt owed to a Federal agency for purposes of section 6402(d) of the Internal Revenue Code of 1986.

"(E) ADMINISTRATIVE FEES.—Any fee charged or allocated for collection activities conducted by the Financial Management Service will be passed on to a health plan on a pro-rata basis and added to any penalty fee collected from the plan.".

(c) PROMULGATION OF RULES.—

(1) UNIQUE HEALTH PLAN IDENTIFIER.—The Secretary shall promulgate a final rule to establish a unique health plan identifier (as described in section 1173(b) of the Social Security Act (42 U.S.C. 1320d-2(b))) based on the input of the National Committee on Vital and Health Statistics. The Secretary may do so on an interim final basis and such

rule shall be effective not later than October 1, 2012.

(2) ELECTRONIC FUNDS TRANSFER.—The Secretary shall promulgate a final rule to establish a standard for electronic funds transfers (as described in section 1173(a)(2)(J) of the Social Security Act, as added by subsection (b)(2)(A)). The Secretary may do so on an interim final basis and shall adopt such standard not later than January 1, 2012, in a manner ensuring that such standard is effective not later than January 1, 2014.

(3) HEALTH CLAIMS ATTACHMENTS.—The Secretary shall promulgate a final rule to establish a transaction standard and a single set of associated operating rules for health claims attachments (as described in section 1173(a)(2)(B) of the Social Security Act (42 U.S.C. 1320d-2(a)(2)(B))) that is consistent with the X12 Version 5010 transaction standards. The Secretary may do so on an interim final basis and shall adopt a transaction standard and a single set of associated operating rules not later than January 1, 2014, in a manner ensuring that such standard is effective not later than January 1, 2016.

(d) EXPANSION OF ELECTRONIC TRANSACTIONS IN MEDICARE.—Section 1862(a) of the Social Security Act (42 U.S.C. 1395y(a)) is amended—

(1) in paragraph (23), by striking the ''or'' at the end;

(2) in paragraph (24), by striking the period and inserting ''; or''; and

(3) by inserting after paragraph (24) the following new paragraph:

''(25) not later than January 1, 2014, for which the payment is other than by electronic funds transfer (EFT) or an electronic remittance in a form as specified in ASC X12 835 Health Care Payment and Remittance Advice or subsequent standard.''.

SEC. 1105. EFFECTIVE DATE.

This subtitle shall take effect on the date of enactment of this Act.

Subtitle C—Quality Health Insurance Coverage for All Americans

PART I—HEALTH INSURANCE MARKET REFORMS

SEC. 1201. AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT.

Part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.), as amended by section 1001, is further amended—

(1) by striking the heading for subpart 1 and inserting the following:

"Subpart I—General Reform";

(2)(A) in section 2701 (42 U.S.C. 300gg), by striking the section heading and subsection (a) and inserting the following:

"SEC. 2704. PROHIBITION OF PREEXISTING CONDITION EXCLUSIONS OR OTHER DISCRIMINATION BASED ON HEALTH STATUS.

''(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage may not impose any preexisting condition exclusion with respect to such plan or coverage.''; and

(B) by transferring such section (as amended by subparagraph (A)) so as to appear after the section 2703 added by paragraph (4);

(3)(A) in section 2702 (42 U.S.C. 300gg-1)—

(i) by striking the section heading and all that follows through subsection (a);

(ii) in subsection (b)—

(I) by striking ''health insurance issuer offering health insurance coverage in connection with a group health plan'' each place that such appears and inserting ''health insurance issuer offering group or individual health insurance coverage''; and

(II) in paragraph (2)(A)—

(aa) by inserting ''or individual'' after ''employer''; and

(bb) by inserting ''or individual health coverage, as the case may be'' before the semicolon; and

(iii) in subsection (e)—

(I) by striking ''(a)(1)(F)'' and inserting ''(a)(6)'';

(II) by striking ''2701'' and inserting ''2704''; and

(III) by striking ''2721(a)'' and inserting ''2735(a)''; and

(B) by transferring such section (as amended by subparagraph (A)) to appear after section 2705(a) as added by paragraph (4); and

(4) by inserting after the subpart heading (as added by paragraph (1)) the following:

"SEC. 2701. FAIR HEALTH INSURANCE PREMIUMS.

"(a) PROHIBITING DISCRIMINATORY PREMIUM RATES.—

"(1) IN GENERAL.—With respect to the premium rate charged by a health insurance issuer for health insurance coverage offered in the individual or small group market—

"(A) such rate shall vary with respect to the particular plan or coverage involved only by—

"(i) whether such plan or coverage covers an individual or family;

"(ii) rating area, as established in accordance with paragraph (2);

"(iii) age, except that such rate shall not vary by more than 3 to 1 for adults (consistent with section 2707(c)); and

"(iv) tobacco use, except that such rate shall not vary by more than 1.5 to 1; and

"(B) such rate shall not vary with respect to the particular plan or coverage involved by any other factor not described in subparagraph (A).

"(2) RATING AREA.—

"(A) IN GENERAL.—Each State shall establish 1 or more rating areas within that State for purposes of applying the requirements of this title.

"(B) SECRETARIAL REVIEW.—The Secretary shall review the rating areas established by each State under subparagraph (A) to ensure the adequacy of such areas for purposes of carrying out the requirements of this title. If the Secretary determines a State's rating areas are not adequate, or that a State does not establish such areas, the Secretary may establish rating areas for that State.

"(3) PERMISSIBLE AGE BANDS.—The Secretary, in consultation with the National Association of Insurance Commissioners, shall define the permissible age bands for rating purposes under paragraph (1)(A)(iii).

"(4) APPLICATION OF VARIATIONS BASED ON AGE OR TOBACCO USE.—With respect to family cov-

erage under a group health plan or health insurance coverage, the rating variations permitted under clauses (iii) and (iv) of paragraph (1)(A) shall be applied based on the portion of the premium that is attributable to each family member covered under the plan or coverage.

"(5) SPECIAL RULE FOR LARGE GROUP MARKET.—If a State permits health insurance issuers that offer coverage in the large group market in the State to offer such coverage through the State Exchange (as provided for under section 1312(f)(2)(B) of the Patient Protection and Affordable Care Act), the provisions of this subsection shall apply to all coverage offered in such market in the State.

"SEC. 2702. GUARANTEED AVAILABILITY OF COVERAGE.

"(a) GUARANTEED ISSUANCE OF COVERAGE IN THE INDIVIDUAL AND GROUP MARKET.—Subject to subsections (b) through (e), each health insurance issuer that offers health insurance coverage in the individual or group market in a State must accept every employer and individual in the State that applies for such coverage.

"(b) ENROLLMENT.—

"(1) RESTRICTION.—A health insurance issuer described in subsection (a) may restrict enrollment

in coverage described in such subsection to open or special enrollment periods.

"(2) ESTABLISHMENT.—A health insurance issuer described in subsection (a) shall, in accordance with the regulations promulgated under paragraph (3), establish special enrollment periods for qualifying events (under section 603 of the Employee Retirement Income Security Act of 1974).

"(3) REGULATIONS.—The Secretary shall promulgate regulations with respect to enrollment periods under paragraphs (1) and (2).

"SEC. 2703. GUARANTEED RENEWABILITY OF COVERAGE.

"(a) IN GENERAL.—Except as provided in this section, if a health insurance issuer offers health insurance coverage in the individual or group market, the issuer must renew or continue in force such coverage at the option of the plan sponsor or the individual, as applicable.

"SEC. 2705. PROHIBITING DISCRIMINATION AGAINST INDIVIDUAL PARTICIPANTS AND BENEFICIARIES BASED ON HEALTH STATUS.

"(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan or coverage based on any of

1 the following health status-related factors in relation to
2 the individual or a dependent of the individual:
3 "(1) Health status.
4 "(2) Medical condition (including both physical
5 and mental illnesses).
6 "(3) Claims experience.
7 "(4) Receipt of health care.
8 "(5) Medical history.
9 "(6) Genetic information.
10 "(7) Evidence of insurability (including condi-
11 tions arising out of acts of domestic violence).
12 "(8) Disability.
13 "(9) Any other health status-related factor de-
14 termined appropriate by the Secretary.
15 "(j) PROGRAMS OF HEALTH PROMOTION OR DIS-
16 EASE PREVENTION.—
17 "(1) GENERAL PROVISIONS.—
18 "(A) GENERAL RULE.—For purposes of
19 subsection (b)(2)(B), a program of health pro-
20 motion or disease prevention (referred to in this
21 subsection as a 'wellness program') shall be a
22 program offered by an employer that is de-
23 signed to promote health or prevent disease
24 that meets the applicable requirements of this
25 subsection.

"(B) NO CONDITIONS BASED ON HEALTH STATUS FACTOR.—If none of the conditions for obtaining a premium discount or rebate or other reward for participation in a wellness program is based on an individual satisfying a standard that is related to a health status factor, such wellness program shall not violate this section if participation in the program is made available to all similarly situated individuals and the requirements of paragraph (2) are complied with.

"(C) CONDITIONS BASED ON HEALTH STATUS FACTOR.—If any of the conditions for obtaining a premium discount or rebate or other reward for participation in a wellness program is based on an individual satisfying a standard that is related to a health status factor, such wellness program shall not violate this section if the requirements of paragraph (3) are complied with.

"(2) WELLNESS PROGRAMS NOT SUBJECT TO REQUIREMENTS.—If none of the conditions for obtaining a premium discount or rebate or other reward under a wellness program as described in paragraph (1)(B) are based on an individual satisfying

a standard that is related to a health status factor (or if such a wellness program does not provide such a reward), the wellness program shall not violate this section if participation in the program is made available to all similarly situated individuals. The following programs shall not have to comply with the requirements of paragraph (3) if participation in the program is made available to all similarly situated individuals:

"(A) A program that reimburses all or part of the cost for memberships in a fitness center.

"(B) A diagnostic testing program that provides a reward for participation and does not base any part of the reward on outcomes.

"(C) A program that encourages preventive care related to a health condition through the waiver of the copayment or deductible requirement under group health plan for the costs of certain items or services related to a health condition (such as prenatal care or well-baby visits).

"(D) A program that reimburses individuals for the costs of smoking cessation pro-

grams without regard to whether the individual quits smoking.

"(E) A program that provides a reward to individuals for attending a periodic health education seminar.

"(3) WELLNESS PROGRAMS SUBJECT TO REQUIREMENTS.—If any of the conditions for obtaining a premium discount, rebate, or reward under a wellness program as described in paragraph (1)(C) is based on an individual satisfying a standard that is related to a health status factor, the wellness program shall not violate this section if the following requirements are complied with:

"(A) The reward for the wellness program, together with the reward for other wellness programs with respect to the plan that requires satisfaction of a standard related to a health status factor, shall not exceed 30 percent of the cost of employee-only coverage under the plan. If, in addition to employees or individuals, any class of dependents (such as spouses or spouses and dependent children) may participate fully in the wellness program, such reward shall not exceed 30 percent of the cost of the coverage in which an employee or individual and any de-

1 pendents are enrolled. For purposes of this
2 paragraph, the cost of coverage shall be deter-
3 mined based on the total amount of employer
4 and employee contributions for the benefit
5 package under which the employee is (or the
6 employee and any dependents are) receiving
7 coverage. A reward may be in the form of a dis-
8 count or rebate of a premium or contribution,
9 a waiver of all or part of a cost-sharing mecha-
10 nism (such as deductibles, copayments, or coin-
11 surance), the absence of a surcharge, or the
12 value of a benefit that would otherwise not be
13 provided under the plan. The Secretaries of
14 Labor, Health and Human Services, and the
15 Treasury may increase the reward available
16 under this subparagraph to up to 50 percent of
17 the cost of coverage if the Secretaries determine
18 that such an increase is appropriate.
19 ''(B) The wellness program shall be rea-
20 sonably designed to promote health or prevent
21 disease. A program complies with the preceding
22 sentence if the program has a reasonable
23 chance of improving the health of, or preventing
24 disease in, participating individuals and it is
25 not overly burdensome, is not a subterfuge for

1 discriminating based on a health status factor,
2 and is not highly suspect in the method chosen
3 to promote health or prevent disease.
4 ''(C) The plan shall give individuals eligible
5 for the program the opportunity to qualify for
6 the reward under the program at least once
7 each year.
8 ''(D) The full reward under the wellness
9 program shall be made available to all similarly
10 situated individuals. For such purpose, among
11 other things:
12 ''(i) The reward is not available to all
13 similarly situated individuals for a period
14 unless the wellness program allows—
15 ''(I) for a reasonable alternative
16 standard (or waiver of the otherwise
17 applicable standard) for obtaining the
18 reward for any individual for whom,
19 for that period, it is unreasonably dif-
20 ficult due to a medical condition to
21 satisfy the otherwise applicable stand-
22 ard; and
23 ''(II) for a reasonable alternative
24 standard (or waiver of the otherwise
25 applicable standard) for obtaining the

reward for any individual for whom, for that period, it is medically inadvisable to attempt to satisfy the otherwise applicable standard.

"(ii) If reasonable under the circumstances, the plan or issuer may seek verification, such as a statement from an individual's physician, that a health status factor makes it unreasonably difficult or medically inadvisable for the individual to satisfy or attempt to satisfy the otherwise applicable standard.

"(E) The plan or issuer involved shall disclose in all plan materials describing the terms of the wellness program the availability of a reasonable alternative standard (or the possibility of waiver of the otherwise applicable standard) required under subparagraph (D). If plan materials disclose that such a program is available, without describing its terms, the disclosure under this subparagraph shall not be required.

"(k) EXISTING PROGRAMS.—Nothing in this section shall prohibit a program of health promotion or disease prevention that was established prior to the date of enact-

1 ment of this section and applied with all applicable regula-
2 tions, and that is operating on such date, from continuing
3 to be carried out for as long as such regulations remain
4 in effect.

5 "(l) WELLNESS PROGRAM DEMONSTRATION
6 PROJECT.—

7 "(1) IN GENERAL.—Not later than July 1,
8 2014, the Secretary, in consultation with the Sec-
9 retary of the Treasury and the Secretary of Labor,
10 shall establish a 10-State demonstration project
11 under which participating States shall apply the pro-
12 visions of subsection (j) to programs of health pro-
13 motion offered by a health insurance issuer that of-
14 fers health insurance coverage in the individual mar-
15 ket in such State.

16 "(2) EXPANSION OF DEMONSTRATION
17 PROJECT.—If the Secretary, in consultation with the
18 Secretary of the Treasury and the Secretary of
19 Labor, determines that the demonstration project
20 described in paragraph (1) is effective, such Secre-
21 taries may, beginning on July 1, 2017 expand such
22 demonstration project to include additional partici-
23 pating States.

24 "(3) REQUIREMENTS.—

"(A) MAINTENANCE OF COVERAGE.—The Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, shall not approve the participation of a State in the demonstration project under this section unless the Secretaries determine that the State's project is designed in a manner that—

"(i) will not result in any decrease in coverage; and

"(ii) will not increase the cost to the Federal Government in providing credits under section 36B of the Internal Revenue Code of 1986 or cost-sharing assistance under section 1402 of the Patient Protection and Affordable Care Act.

"(B) OTHER REQUIREMENTS.—States that participate in the demonstration project under this subsection—

"(i) may permit premium discounts or rebates or the modification of otherwise applicable copayments or deductibles for adherence to, or participation in, a reasonably designed program of health promotion and disease prevention;

1 "(ii) shall ensure that requirements of
2 consumer protection are met in programs
3 of health promotion in the individual mar-
4 ket;
5 "(iii) shall require verification from
6 health insurance issuers that offer health
7 insurance coverage in the individual mar-
8 ket of such State that premium dis-
9 counts—
10 "(I) do not create undue burdens
11 for individuals insured in the indi-
12 vidual market;
13 "(II) do not lead to cost shifting;
14 and
15 "(III) are not a subterfuge for
16 discrimination;
17 "(iv) shall ensure that consumer data
18 is protected in accordance with the require-
19 ments of section 264(c) of the Health In-
20 surance Portability and Accountability Act
21 of 1996 (42 U.S.C. 1320d-2 note); and
22 "(v) shall ensure and demonstrate to
23 the satisfaction of the Secretary that the
24 discounts or other rewards provided under
25 the project reflect the expected level of par-

1 ticipation in the wellness program involved
2 and the anticipated effect the program will
3 have on utilization or medical claim costs.
4 "(m) REPORT.—
5 "(1) IN GENERAL.—Not later than 3 years
6 after the date of enactment of the Patient Protection
7 and Affordable Care Act, the Secretary, in consulta-
8 tion with the Secretary of the Treasury and the Sec-
9 retary of Labor, shall submit a report to the appro-
10 priate committees of Congress concerning—
11 "(A) the effectiveness of wellness programs
12 (as defined in subsection (j)) in promoting
13 health and preventing disease;
14 "(B) the impact of such wellness programs
15 on the access to care and affordability of cov-
16 erage for participants and non-participants of
17 such programs;
18 "(C) the impact of premium-based and
19 cost-sharing incentives on participant behavior
20 and the role of such programs in changing be-
21 havior; and
22 "(D) the effectiveness of different types of
23 rewards.
24 "(2) DATA COLLECTION.—In preparing the re-
25 port described in paragraph (1), the Secretaries

shall gather relevant information from employers who provide employees with access to wellness programs, including State and Federal agencies.

"(n) REGULATIONS.—Nothing in this section shall be construed as prohibiting the Secretaries of Labor, Health and Human Services, or the Treasury from promulgating regulations in connection with this section.

"SEC. 2706. NON-DISCRIMINATION IN HEALTH CARE.

"(a) PROVIDERS.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law. This section shall not require that a group health plan or health insurance issuer contract with any health care provider willing to abide by the terms and conditions for participation established by the plan or issuer. Nothing in this section shall be construed as preventing a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures.

"(b) INDIVIDUALS.—The provisions of section 1558 of the Patient Protection and Affordable Care Act (relating to non-discrimination) shall apply with respect to a

group health plan or health insurance issuer offering group or individual health insurance coverage.

"SEC. 2707. COMPREHENSIVE HEALTH INSURANCE COVERAGE.

"(a) COVERAGE FOR ESSENTIAL HEALTH BENEFITS PACKAGE.—A health insurance issuer that offers health insurance coverage in the individual or small group market shall ensure that such coverage includes the essential health benefits package required under section 1302(a) of the Patient Protection and Affordable Care Act.

"(b) COST-SHARING UNDER GROUP HEALTH PLANS.—A group health plan shall ensure that any annual cost-sharing imposed under the plan does not exceed the limitations provided for under paragraphs (1) and (2) of section 1302(c).

"(c) CHILD-ONLY PLANS.—If a health insurance issuer offers health insurance coverage in any level of coverage specified under section 1302(d) of the Patient Protection and Affordable Care Act, the issuer shall also offer such coverage in that level as a plan in which the only enrollees are individuals who, as of the beginning of a plan year, have not attained the age of 21.

"(d) DENTAL ONLY.—This section shall not apply to a plan described in section 1302(d)(2)(B)(ii)(I).

"SEC. 2708. PROHIBITION ON EXCESSIVE WAITING PERIODS.

''A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not apply any waiting period (as defined in section 2704(b)(4)) that exceeds 90 days.''.

PART II—OTHER PROVISIONS

SEC. 1251. PRESERVATION OF RIGHT TO MAINTAIN EXISTING COVERAGE.

(a) NO CHANGES TO EXISTING COVERAGE.—

(1) IN GENERAL.—Nothing in this Act (or an amendment made by this Act) shall be construed to require that an individual terminate coverage under a group health plan or health insurance coverage in which such individual was enrolled on the date of enactment of this Act.

(2) CONTINUATION OF COVERAGE.—With respect to a group health plan or health insurance coverage in which an individual was enrolled on the date of enactment of this Act, this subtitle and subtitle A (and the amendments made by such subtitles) shall not apply to such plan or coverage, regardless of whether the individual renews such coverage after such date of enactment.

(b) ALLOWANCE FOR FAMILY MEMBERS TO JOIN CURRENT COVERAGE.—With respect to a group health

1 plan or health insurance coverage in which an individual
2 was enrolled on the date of enactment of this Act and
3 which is renewed after such date, family members of such
4 individual shall be permitted to enroll in such plan or cov-
5 erage if such enrollment is permitted under the terms of
6 the plan in effect as of such date of enactment.

7 (c) ALLOWANCE FOR NEW EMPLOYEES TO JOIN
8 CURRENT PLAN.—A group health plan that provides cov-
9 erage on the date of enactment of this Act may provide
10 for the enrolling of new employees (and their families) in
11 such plan, and this subtitle and subtitle A (and the
12 amendments made by such subtitles) shall not apply with
13 respect to such plan and such new employees (and their
14 families).

15 (d) EFFECT ON COLLECTIVE BARGAINING AGREE-
16 MENTS.—In the case of health insurance coverage main-
17 tained pursuant to one or more collective bargaining
18 agreements between employee representatives and one or
19 more employers that was ratified before the date of enact-
20 ment of this Act, the provisions of this subtitle and sub-
21 title A (and the amendments made by such subtitles) shall
22 not apply until the date on which the last of the collective
23 bargaining agreements relating to the coverage termi-
24 nates. Any coverage amendment made pursuant to a col-
25 lective bargaining agreement relating to the coverage

which amends the coverage solely to conform to any requirement added by this subtitle or subtitle A (or amendments) shall not be treated as a termination of such collective bargaining agreement.

(e) DEFINITION.—In this title, the term ''grandfathered health plan'' means any group health plan or health insurance coverage to which this section applies.

SEC. 1252. RATING REFORMS MUST APPLY UNIFORMLY TO ALL HEALTH INSURANCE ISSUERS AND GROUP HEALTH PLANS.

Any standard or requirement adopted by a State pursuant to this title, or any amendment made by this title, shall be applied uniformly to all health plans in each insurance market to which the standard and requirements apply. The preceding sentence shall also apply to a State standard or requirement relating to the standard or requirement required by this title (or any such amendment) that is not the same as the standard or requirement but that is not preempted under section 1321(d).

SEC. 1253. EFFECTIVE DATES.

This subtitle (and the amendments made by this subtitle) shall become effective for plan years beginning on or after January 1, 2014.

Subtitle D—Available Coverage Choices for All Americans

PART I—ESTABLISHMENT OF QUALIFIED HEALTH PLANS

SEC. 1301. QUALIFIED HEALTH PLAN DEFINED.

(a) QUALIFIED HEALTH PLAN.—In this title:

(1) IN GENERAL.—The term ''qualified health plan'' means a health plan that—

(A) has in effect a certification (which may include a seal or other indication of approval) that such plan meets the criteria for certification described in section 1311(c) issued or recognized by each Exchange through which such plan is offered;

(B) provides the essential health benefits package described in section 1302(a); and

(C) is offered by a health insurance issuer that—

(i) is licensed and in good standing to offer health insurance coverage in each State in which such issuer offers health insurance coverage under this title;

(ii) agrees to offer at least one qualified health plan in the silver level and at

1 least one plan in the gold level in each
2 such Exchange;
3 (iii) agrees to charge the same pre-
4 mium rate for each qualified health plan of
5 the issuer without regard to whether the
6 plan is offered through an Exchange or
7 whether the plan is offered directly from
8 the issuer or through an agent; and
9 (iv) complies with the regulations de-
10 veloped by the Secretary under section
11 1311(d) and such other requirements as
12 an applicable Exchange may establish.
13 (2) INCLUSION OF CO-OP PLANS AND COMMU-
14 NITY HEALTH INSURANCE OPTION.—Any reference
15 in this title to a qualified health plan shall be
16 deemed to include a qualified health plan offered
17 through the CO-OP program under section 1322 or
18 a community health insurance option under section
19 1323, unless specifically provided for otherwise.
20 (b) TERMS RELATING TO HEALTH PLANS.—In this
21 title:
22 (1) HEALTH PLAN.—
23 (A) IN GENERAL.—The term ''health plan''
24 means health insurance coverage and a group
25 health plan.

(B) EXCEPTION FOR SELF-INSURED PLANS AND MEWAS.—Except to the extent specifically provided by this title, the term ''health plan'' shall not include a group health plan or multiple employer welfare arrangement to the extent the plan or arrangement is not subject to State insurance regulation under section 514 of the Employee Retirement Income Security Act of 1974.

(2) HEALTH INSURANCE COVERAGE AND ISSUER.—The terms ''health insurance coverage'' and ''health insurance issuer'' have the meanings given such terms by section 2791(b) of the Public Health Service Act.

(3) GROUP HEALTH PLAN.—The term ''group health plan'' has the meaning given such term by section 2791(a) of the Public Health Service Act.

SEC. 1302. ESSENTIAL HEALTH BENEFITS REQUIREMENTS.

(a) ESSENTIAL HEALTH BENEFITS PACKAGE.—In this title, the term ''essential health benefits package'' means, with respect to any health plan, coverage that—

(1) provides for the essential health benefits defined by the Secretary under subsection (b);

(2) limits cost-sharing for such coverage in accordance with subsection (c); and

(3) subject to subsection (e), provides either the bronze, silver, gold, or platinum level of coverage described in subsection (d).

(b) ESSENTIAL HEALTH BENEFITS.—

(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories:

(A) Ambulatory patient services.

(B) Emergency services.

(C) Hospitalization.

(D) Maternity and newborn care.

(E) Mental health and substance use disorder services, including behavioral health treatment.

(F) Prescription drugs.

(G) Rehabilitative and habilitative services and devices.

(H) Laboratory services.

(I) Preventive and wellness services and chronic disease management.

(J) Pediatric services, including oral and vision care.

(2) LIMITATION.—

1 (A) IN GENERAL.—The Secretary shall en-
2 sure that the scope of the essential health bene-
3 fits under paragraph (1) is equal to the scope
4 of benefits provided under a typical employer
5 plan, as determined by the Secretary. To in-
6 form this determination, the Secretary of Labor
7 shall conduct a survey of employer-sponsored
8 coverage to determine the benefits typically cov-
9 ered by employers, including multiemployer
10 plans, and provide a report on such survey to
11 the Secretary.
12 (B) CERTIFICATION.—In defining the es-
13 sential health benefits described in paragraph
14 (1), and in revising the benefits under para-
15 graph (4)(H), the Secretary shall submit a re-
16 port to the appropriate committees of Congress
17 containing a certification from the Chief Actu-
18 ary of the Centers for Medicare & Medicaid
19 Services that such essential health benefits meet
20 the limitation described in paragraph (2).
21 (3) NOTICE AND HEARING.—In defining the es-
22 sential health benefits described in paragraph (1),
23 and in revising the benefits under paragraph (4)(H),
24 the Secretary shall provide notice and an oppor-
25 tunity for public comment.

1 (4) REQUIRED ELEMENTS FOR CONSIDER-
2 ATION.—In defining the essential health benefits
3 under paragraph (1), the Secretary shall—
4 (A) ensure that such essential health bene-
5 fits reflect an appropriate balance among the
6 categories described in such subsection, so that
7 benefits are not unduly weighted toward any
8 category;
9 (B) not make coverage decisions, deter-
10 mine reimbursement rates, establish incentive
11 programs, or design benefits in ways that dis-
12 criminate against individuals because of their
13 age, disability, or expected length of life;
14 (C) take into account the health care needs
15 of diverse segments of the population, including
16 women, children, persons with disabilities, and
17 other groups;
18 (D) ensure that health benefits established
19 as essential not be subject to denial to individ-
20 uals against their wishes on the basis of the in-
21 dividuals' age or expected length of life or of
22 the individuals' present or predicted disability,
23 degree of medical dependency, or quality of life;
24 (E) provide that a qualified health plan
25 shall not be treated as providing coverage for

1 the essential health benefits described in para-
2 graph (1) unless the plan provides that—
3 (i) coverage for emergency department
4 services will be provided without imposing
5 any requirement under the plan for prior
6 authorization of services or any limitation
7 on coverage where the provider of services
8 does not have a contractual relationship
9 with the plan for the providing of services
10 that is more restrictive than the require-
11 ments or limitations that apply to emer-
12 gency department services received from
13 providers who do have such a contractual
14 relationship with the plan; and
15 (ii) if such services are provided out-
16 of-network, the cost-sharing requirement
17 (expressed as a copayment amount or coin-
18 surance rate) is the same requirement that
19 would apply if such services were provided
20 in-network;
21 (F) provide that if a plan described in sec-
22 tion 1311(b)(2)(B)(ii) (relating to stand-alone
23 dental benefits plans) is offered through an Ex-
24 change, another health plan offered through
25 such Exchange shall not fail to be treated as a

1 qualified health plan solely because the plan
2 does not offer coverage of benefits offered
3 through the stand-alone plan that are otherwise
4 required under paragraph (1)(J); and
5 (G) periodically review the essential health
6 benefits under paragraph (1), and provide a re-
7 port to Congress and the public that contains—
8 (i) an assessment of whether enrollees
9 are facing any difficulty accessing needed
10 services for reasons of coverage or cost;
11 (ii) an assessment of whether the es-
12 sential health benefits needs to be modified
13 or updated to account for changes in med-
14 ical evidence or scientific advancement;
15 (iii) information on how the essential
16 health benefits will be modified to address
17 any such gaps in access or changes in the
18 evidence base;
19 (iv) an assessment of the potential of
20 additional or expanded benefits to increase
21 costs and the interactions between the ad-
22 dition or expansion of benefits and reduc-
23 tions in existing benefits to meet actuarial
24 limitations described in paragraph (2); and

1 (H) periodically update the essential health
2 benefits under paragraph (1) to address any
3 gaps in access to coverage or changes in the
4 evidence base the Secretary identifies in the re-
5 view conducted under subparagraph (G).
6 (5) RULE OF CONSTRUCTION.—Nothing in this
7 title shall be construed to prohibit a health plan
8 from providing benefits in excess of the essential
9 health benefits described in this subsection.
10 (c) REQUIREMENTS RELATING TO COST-SHARING.—
11 (1) ANNUAL LIMITATION ON COST-SHARING.—
12 (A) 2014.—The cost-sharing incurred
13 under a health plan with respect to self-only
14 coverage or coverage other than self-only cov-
15 erage for a plan year beginning in 2014 shall
16 not exceed the dollar amounts in effect under
17 section 223(c)(2)(A)(ii) of the Internal Revenue
18 Code of 1986 for self-only and family coverage,
19 respectively, for taxable years beginning in
20 2014.
21 (B) 2015 AND LATER.—In the case of any
22 plan year beginning in a calendar year after
23 2014, the limitation under this paragraph
24 shall—

(i) in the case of self-only coverage, be equal to the dollar amount under subparagraph (A) for self-only coverage for plan years beginning in 2014, increased by an amount equal to the product of that amount and the premium adjustment percentage under paragraph (4) for the calendar year; and

(ii) in the case of other coverage, twice the amount in effect under clause (i).

If the amount of any increase under clause (i) is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.

(2) ANNUAL LIMITATION ON DEDUCTIBLES FOR EMPLOYER-SPONSORED PLANS.—

(A) IN GENERAL.—In the case of a health plan offered in the small group market, the deductible under the plan shall not exceed—

(i) $2,000 in the case of a plan covering a single individual; and

(ii) $4,000 in the case of any other plan.

The amounts under clauses (i) and (ii) may be increased by the maximum amount of reimbursement which is reasonably available to a

1 participant under a flexible spending arrange-
2 ment described in section 106(c)(2) of the In-
3 ternal Revenue Code of 1986 (determined with-
4 out regard to any salary reduction arrange-
5 ment).

6 (B) INDEXING OF LIMITS.—In the case of
7 any plan year beginning in a calendar year
8 after 2014—

9 (i) the dollar amount under subpara-
10 graph (A)(i) shall be increased by an
11 amount equal to the product of that
12 amount and the premium adjustment per-
13 centage under paragraph (4) for the cal-
14 endar year; and

15 (ii) the dollar amount under subpara-
16 graph (A)(ii) shall be increased to an
17 amount equal to twice the amount in effect
18 under subparagraph (A)(i) for plan years
19 beginning in the calendar year, determined
20 after application of clause (i).

21 If the amount of any increase under clause (i)
22 is not a multiple of $50, such increase shall be
23 rounded to the next lowest multiple of $50.

24 (C) ACTUARIAL VALUE.—The limitation
25 under this paragraph shall be applied in such a

1 manner so as to not affect the actuarial value
2 of any health plan, including a plan in the
3 bronze level.
4 (D) COORDINATION WITH PREVENTIVE
5 LIMITS.—Nothing in this paragraph shall be
6 construed to allow a plan to have a deductible
7 under the plan apply to benefits described in
8 section 2713 of the Public Health Service Act.
9 (3) COST-SHARING.—In this title—
10 (A) IN GENERAL.—The term ''cost-shar-
11 ing'' includes—
12 (i) deductibles, coinsurance, copay-
13 ments, or similar charges; and
14 (ii) any other expenditure required of
15 an insured individual which is a qualified
16 medical expense (within the meaning of
17 section 223(d)(2) of the Internal Revenue
18 Code of 1986) with respect to essential
19 health benefits covered under the plan.
20 (B) EXCEPTIONS.—Such term does not in-
21 clude premiums, balance billing amounts for
22 non-network providers, or spending for non-cov-
23 ered services.
24 (4) PREMIUM ADJUSTMENT PERCENTAGE.—For
25 purposes of paragraphs (1)(B)(i) and (2)(B)(i), the

premium adjustment percentage for any calendar year is the percentage (if any) by which the average per capita premium for health insurance coverage in the United States for the preceding calendar year (as estimated by the Secretary no later than October 1 of such preceding calendar year) exceeds such average per capita premium for 2013 (as determined by the Secretary).

(d) LEVELS OF COVERAGE.—

(1) LEVELS OF COVERAGE DEFINED.—The levels of coverage described in this subsection are as follows:

(A) BRONZE LEVEL.—A plan in the bronze level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the plan.

(B) SILVER LEVEL.—A plan in the silver level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the plan.

(C) GOLD LEVEL.—A plan in the gold level shall provide a level of coverage that is designed to provide benefits that are actuarially equiva-

1 lent to 80 percent of the full actuarial value of
2 the benefits provided under the plan.
3 (D) PLATINUM LEVEL.—A plan in the
4 platinum level shall provide a level of coverage
5 that is designed to provide benefits that are ac-
6 tuarially equivalent to 90 percent of the full ac-
7 tuarial value of the benefits provided under the
8 plan.
9 (2) ACTUARIAL VALUE.—
10 (A) IN GENERAL.—Under regulations
11 issued by the Secretary, the level of coverage of
12 a plan shall be determined on the basis that the
13 essential health benefits described in subsection
14 (b) shall be provided to a standard population
15 (and without regard to the population the plan
16 may actually provide benefits to).
17 (B) EMPLOYER CONTRIBUTIONS.—The
18 Secretary may issue regulations under which
19 employer contributions to a health savings ac-
20 count (within the meaning of section 223 of the
21 Internal Revenue Code of 1986) may be taken
22 into account in determining the level of cov-
23 erage for a plan of the employer.
24 (C) APPLICATION.—In determining under
25 this title, the Public Health Service Act, or the

1 Internal Revenue Code of 1986 the percentage
2 of the total allowed costs of benefits provided
3 under a group health plan or health insurance
4 coverage that are provided by such plan or cov-
5 erage, the rules contained in the regulations
6 under this paragraph shall apply.

7 (3) ALLOWABLE VARIANCE.—The Secretary
8 shall develop guidelines to provide for a de minimis
9 variation in the actuarial valuations used in deter-
10 mining the level of coverage of a plan to account for
11 differences in actuarial estimates.

12 (4) PLAN REFERENCE.—In this title, any ref-
13 erence to a bronze, silver, gold, or platinum plan
14 shall be treated as a reference to a qualified health
15 plan providing a bronze, silver, gold, or platinum
16 level of coverage, as the case may be.

17 (e) CATASTROPHIC PLAN.—

18 (1) IN GENERAL.—A health plan not providing
19 a bronze, silver, gold, or platinum level of coverage
20 shall be treated as meeting the requirements of sub-
21 section (d) with respect to any plan year if—

22 (A) the only individuals who are eligible to
23 enroll in the plan are individuals described in
24 paragraph (2); and

25 (B) the plan provides—

(i) except as provided in clause (ii), the essential health benefits determined under subsection (b), except that the plan provides no benefits for any plan year until the individual has incurred cost-sharing expenses in an amount equal to the annual limitation in effect under subsection (c)(1) for the plan year (except as provided for in section 2713); and

(ii) coverage for at least three primary care visits.

(2) INDIVIDUALS ELIGIBLE FOR ENROLLMENT.—An individual is described in this paragraph for any plan year if the individual—

(A) has not attained the age of 30 before the beginning of the plan year; or

(B) has a certification in effect for any plan year under this title that the individual is exempt from the requirement under section 5000A of the Internal Revenue Code of 1986 by reason of—

(i) section 5000A(e)(1) of such Code (relating to individuals without affordable coverage); or

(ii) section 5000A(e)(5) of such Code (relating to individuals with hardships).

(3) RESTRICTION TO INDIVIDUAL MARKET.—If a health insurance issuer offers a health plan described in this subsection, the issuer may only offer the plan in the individual market.

(f) CHILD-ONLY PLANS.—If a qualified health plan is offered through the Exchange in any level of coverage specified under subsection (d), the issuer shall also offer that plan through the Exchange in that level as a plan in which the only enrollees are individuals who, as of the beginning of a plan year, have not attained the age of 21, and such plan shall be treated as a qualified health plan.

SEC. 1303. SPECIAL RULES.

(a) SPECIAL RULES RELATING TO COVERAGE OF ABORTION SERVICES.—

(1) VOLUNTARY CHOICE OF COVERAGE OF ABORTION SERVICES.—

(A) IN GENERAL.—Notwithstanding any other provision of this title (or any amendment made by this title), and subject to subparagraphs (C) and (D)—

(i) nothing in this title (or any amendment made by this title), shall be construed to require a qualified health plan

1 to provide coverage of services described in
2 subparagraph (B)(i) or (B)(ii) as part of
3 its essential health benefits for any plan
4 year; and
5 (ii) the issuer of a qualified health
6 plan shall determine whether or not the
7 plan provides coverage of services described
8 in subparagraph (B)(i) or (B)(ii) as part
9 of such benefits for the plan year.
10 (B) ABORTION SERVICES.—
11 (i) ABORTIONS FOR WHICH PUBLIC
12 FUNDING IS PROHIBITED.—The services
13 described in this clause are abortions for
14 which the expenditure of Federal funds ap-
15 propriated for the Department of Health
16 and Human Services is not permitted,
17 based on the law as in effect as of the date
18 that is 6 months before the beginning of
19 the plan year involved.
20 (ii) ABORTIONS FOR WHICH PUBLIC
21 FUNDING IS ALLOWED.—The services de-
22 scribed in this clause are abortions for
23 which the expenditure of Federal funds ap-
24 propriated for the Department of Health
25 and Human Services is permitted, based

on the law as in effect as of the date that is 6 months before the beginning of the plan year involved.

(C) PROHIBITION ON FEDERAL FUNDS FOR ABORTION SERVICES IN COMMUNITY HEALTH INSURANCE OPTION.—

(i) DETERMINATION BY SECRETARY.—The Secretary may not determine, in accordance with subparagraph (A)(ii), that the community health insurance option established under section 1323 shall provide coverage of services described in subparagraph (B)(i) as part of benefits for the plan year unless the Secretary—

(I) assures compliance with the requirements of paragraph (2);

(II) assures, in accordance with applicable provisions of generally accepted accounting requirements, circulars on funds management of the Office of Management and Budget, and guidance on accounting of the Government Accountability Office, that no Federal funds are used for such coverage; and

1 (III) notwithstanding section
2 1323(e)(1)(C) or any other provision
3 of this title, takes all necessary steps
4 to assure that the United States does
5 not bear the insurance risk for a com-
6 munity health insurance option's cov-
7 erage of services described in subpara-
8 graph (B)(i).
9 (ii) STATE REQUIREMENT.—If a State
10 requires, in addition to the essential health
11 benefits required under section 1323(b)(3)
12 (A), coverage of services described in sub-
13 paragraph (B)(i) for enrollees of a commu-
14 nity health insurance option offered in
15 such State, the State shall assure that no
16 funds flowing through or from the commu-
17 nity health insurance option, and no other
18 Federal funds, pay or defray the cost of
19 providing coverage of services described in
20 subparagraph (B)(i). The United States
21 shall not bear the insurance risk for a
22 State's required coverage of services de-
23 scribed in subparagraph (B)(i).
24 (iii) EXCEPTIONS.—Nothing in this
25 subparagraph shall apply to coverage of

1 services described in subparagraph (B)(ii)
2 by the community health insurance option.
3 Services described in subparagraph (B)(ii)
4 shall be covered to the same extent as such
5 services are covered under title XIX of the
6 Social Security Act.
7 (D) ASSURED AVAILABILITY OF VARIED
8 COVERAGE THROUGH EXCHANGES.—
9 (i) IN GENERAL.—The Secretary shall
10 assure that with respect to qualified health
11 plans offered in any Exchange established
12 pursuant to this title—
13 (I) there is at least one such plan
14 that provides coverage of services de-
15 scribed in clauses (i) and (ii) of sub-
16 paragraph (B); and
17 (II) there is at least one such
18 plan that does not provide coverage of
19 services described in subparagraph
20 (B)(i).
21 (ii) SPECIAL RULES.—For purposes of
22 clause (i)—
23 (I) a plan shall be treated as de-
24 scribed in clause (i)(II) if the plan
25 does not provide coverage of services

1 described in either subparagraph
2 (B)(i) or (B)(ii); and
3 (II) if a State has one Exchange
4 covering more than 1 insurance mar-
5 ket, the Secretary shall meet the re-
6 quirements of clause (i) separately
7 with respect to each such market.
8 (2) PROHIBITION ON THE USE OF FEDERAL
9 FUNDS.—
10 (A) IN GENERAL.—If a qualified health
11 plan provides coverage of services described in
12 paragraph (1)(B)(i), the issuer of the plan shall
13 not use any amount attributable to any of the
14 following for purposes of paying for such serv-
15 ices:
16 (i) The credit under section 36B of
17 the Internal Revenue Code of 1986 (and
18 the amount (if any) of the advance pay-
19 ment of the credit under section 1412 of
20 the Patient Protection and Affordable Care
21 Act).
22 (ii) Any cost-sharing reduction under
23 section 1402 of thePatient Protection and
24 Affordable Care Act (and the amount (if
25 any) of the advance payment of the reduc-

1 tion under section 1412 of the Patient
2 Protection and Affordable Care Act).
3 (B) SEGREGATION OF FUNDS.—In the case
4 of a plan to which subparagraph (A) applies,
5 the issuer of the plan shall, out of amounts not
6 described in subparagraph (A), segregate an
7 amount equal to the actuarial amounts deter-
8 mined under subparagraph (C) for all enrollees
9 from the amounts described in subparagraph
10 (A).
11 (C) ACTUARIAL VALUE OF OPTIONAL
12 SERVICE COVERAGE.—
13 (i) IN GENERAL.—The Secretary shall
14 estimate the basic per enrollee, per month
15 cost, determined on an average actuarial
16 basis, for including coverage under a quali-
17 fied health plan of the services described in
18 paragraph (1)(B)(i).
19 (ii) CONSIDERATIONS.—In making
20 such estimate, the Secretary—
21 (I) may take into account the im-
22 pact on overall costs of the inclusion
23 of such coverage, but may not take
24 into account any cost reduction esti-
25 mated to result from such services, in-

1 cluding prenatal care, delivery, or
2 postnatal care;
3 (II) shall estimate such costs as
4 if such coverage were included for the
5 entire population covered; and
6 (III) may not estimate such a
7 cost at less than $1 per enrollee, per
8 month.
9 (3) PROVIDER CONSCIENCE PROTECTIONS.—No
10 individual health care provider or health care facility
11 may be discriminated against because of a willing-
12 ness or an unwillingness, if doing so is contrary to
13 the religious or moral beliefs of the provider or facil-
14 ity, to provide, pay for, provide coverage of, or refer
15 for abortions.
16 (b) APPLICATION OF STATE AND FEDERAL LAWS
17 REGARDING ABORTION.—
18 (1) NO PREEMPTION OF STATE LAWS REGARD-
19 ING ABORTION.—Nothing in this Act shall be con-
20 strued to preempt or otherwise have any effect on
21 State laws regarding the prohibition of (or require-
22 ment of) coverage, funding, or procedural require-
23 ments on abortions, including parental notification
24 or consent for the performance of an abortion on a
25 minor.

(2) NO EFFECT ON FEDERAL LAWS REGARDING ABORTION.—

(A) IN GENERAL.—Nothing in this Act shall be construed to have any effect on Federal laws regarding—

(i) conscience protection;

(ii) willingness or refusal to provide abortion; and

(iii) discrimination on the basis of the willingness or refusal to provide, pay for, cover, or refer for abortion or to provide or participate in training to provide abortion.

(3) NO EFFECT ON FEDERAL CIVIL RIGHTS LAW.—Nothing in this subsection shall alter the rights and obligations of employees and employers under title VII of the Civil Rights Act of 1964.

(c) APPLICATION OF EMERGENCY SERVICES LAWS.—Nothing in this Act shall be construed to relieve any health care provider from providing emergency services as required by State or Federal law, including section 1867 of the Social Security Act (popularly known as ''EMTALA'').

SEC. 1304. RELATED DEFINITIONS.

(a) DEFINITIONS RELATING TO MARKETS.—In this title:

1 (1) GROUP MARKET.—The term ''group mar-
2 ket'' means the health insurance market under
3 which individuals obtain health insurance coverage
4 (directly or through any arrangement) on behalf of
5 themselves (and their dependents) through a group
6 health plan maintained by an employer.
7 (2) INDIVIDUAL MARKET.—The term ''indi-
8 vidual market'' means the market for health insur-
9 ance coverage offered to individuals other than in
10 connection with a group health plan.
11 (3) LARGE AND SMALL GROUP MARKETS.—The
12 terms ''large group market'' and ''small group mar-
13 ket'' mean the health insurance market under which
14 individuals obtain health insurance coverage (directly
15 or through any arrangement) on behalf of them-
16 selves (and their dependents) through a group health
17 plan maintained by a large employer (as defined in
18 subsection (b)(1)) or by a small employer (as defined
19 in subsection (b)(2)), respectively.
20 (b) EMPLOYERS.—In this title:
21 (1) LARGE EMPLOYER.—The term ''large em-
22 ployer'' means, in connection with a group health
23 plan with respect to a calendar year and a plan year,
24 an employer who employed an average of at least
25 101 employees on business days during the pre-

ceding calendar year and who employs at least 1 employee on the first day of the plan year.

(2) SMALL EMPLOYER.—The term ''small employer'' means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.

(3) STATE OPTION TO TREAT 50 EMPLOYEES AS SMALL.—In the case of plan years beginning before January 1, 2016, a State may elect to apply this subsection by substituting ''51 employees'' for ''101 employees'' in paragraph (1) and by substituting ''50 employees'' for ''100 employees'' in paragraph (2).

(4) RULES FOR DETERMINING EMPLOYER SIZE.—For purposes of this subsection—

(A) APPLICATION OF AGGREGATION RULE FOR EMPLOYERS.—All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as 1 employer.

(B) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer

which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small or large employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

(C) PREDECESSORS.—Any reference in this subsection to an employer shall include a reference to any predecessor of such employer.

(D) CONTINUATION OF PARTICIPATION FOR GROWING SMALL EMPLOYERS.—If—

(i) a qualified employer that is a small employer makes enrollment in qualified health plans offered in the small group market available to its employees through an Exchange; and

(ii) the employer ceases to be a small employer by reason of an increase in the number of employees of such employer;

the employer shall continue to be treated as a small employer for purposes of this subtitle for the period beginning with the increase and ending with the first day on which the employer

1 does not make such enrollment available to its
2 employees.
3 (c) SECRETARY.—In this title, the term ''Secretary''
4 means the Secretary of Health and Human Services.
5 (d) STATE.—In this title, the term ''State'' means
6 each of the 50 States and the District of Columbia.

7 **PART II—CONSUMER CHOICES AND INSURANCE**
8 **COMPETITION THROUGH HEALTH BENEFIT**
9 **EXCHANGES**

10 **SEC. 1311. AFFORDABLE CHOICES OF HEALTH BENEFIT**
11 **PLANS.**

12 (a) ASSISTANCE TO STATES TO ESTABLISH AMER-
13 ICAN HEALTH BENEFIT EXCHANGES.—
14 (1) PLANNING AND ESTABLISHMENT
15 GRANTS.—There shall be appropriated to the Sec-
16 retary, out of any moneys in the Treasury not other-
17 wise appropriated, an amount necessary to enable
18 the Secretary to make awards, not later than 1 year
19 after the date of enactment of this Act, to States in
20 the amount specified in paragraph (2) for the uses
21 described in paragraph (3).
22 (2) AMOUNT SPECIFIED.—For each fiscal year,
23 the Secretary shall determine the total amount that
24 the Secretary will make available to each State for
25 grants under this subsection.

(3) USE OF FUNDS.—A State shall use amounts awarded under this subsection for activities (including planning activities) related to establishing an American Health Benefit Exchange, as described in subsection (b).

(4) RENEWABILITY OF GRANT.—

(A) IN GENERAL.—Subject to subsection (d)(4), the Secretary may renew a grant awarded under paragraph (1) if the State recipient of such grant—

(i) is making progress, as determined by the Secretary, toward—

(I) establishing an Exchange; and

(II) implementing the reforms described in subtitles A and C (and the amendments made by such subtitles); and

(ii) is meeting such other benchmarks as the Secretary may establish.

(B) LIMITATION.—No grant shall be awarded under this subsection after January 1, 2015.

(5) TECHNICAL ASSISTANCE TO FACILITATE PARTICIPATION IN SHOP EXCHANGES.—The Sec-

1 retary shall provide technical assistance to States to
2 facilitate the participation of qualified small busi-
3 nesses in such States in SHOP Exchanges.
4 (b) AMERICAN HEALTH BENEFIT EXCHANGES.—
5 (1) IN GENERAL.—Each State shall, not later
6 than January 1, 2014, establish an American Health
7 Benefit Exchange (referred to in this title as an
8 ''Exchange'') for the State that—
9 (A) facilitates the purchase of qualified
10 health plans;
11 (B) provides for the establishment of a
12 Small Business Health Options Program (in
13 this title referred to as a ''SHOP Exchange'')
14 that is designed to assist qualified employers in
15 the State who are small employers in facili-
16 tating the enrollment of their employees in
17 qualified health plans offered in the small group
18 market in the State; and
19 (C) meets the requirements of subsection
20 (d).
21 (2) MERGER OF INDIVIDUAL AND SHOP EX-
22 CHANGES.—A State may elect to provide only one
23 Exchange in the State for providing both Exchange
24 and SHOP Exchange services to both qualified indi-
25 viduals and qualified small employers, but only if the

1 Exchange has adequate resources to assist such indi-
2 viduals and employers.
3 (c) RESPONSIBILITIES OF THE SECRETARY.—
4 (1) IN GENERAL.—The Secretary shall, by reg-
5 ulation, establish criteria for the certification of
6 health plans as qualified health plans. Such criteria
7 shall require that, to be certified, a plan shall, at a
8 minimum—
9 (A) meet marketing requirements, and not
10 employ marketing practices or benefit designs
11 that have the effect of discouraging the enroll-
12 ment in such plan by individuals with signifi-
13 cant health needs;
14 (B) ensure a sufficient choice of providers
15 (in a manner consistent with applicable network
16 adequacy provisions under section 2702(c) of
17 the Public Health Service Act), and provide in-
18 formation to enrollees and prospective enrollees
19 on the availability of in-network and out-of-net-
20 work providers;
21 (C) include within health insurance plan
22 networks those essential community providers,
23 where available, that serve predominately low-
24 income, medically-underserved individuals, such
25 as health care providers defined in section

340B(a)(4) of the Public Health Service Act and providers described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act as set forth by section 221 of Public Law 111-8, except that nothing in this subparagraph shall be construed to require any health plan to provide coverage for any specific medical procedure;

(D)(i) be accredited with respect to local performance on clinical quality measures such as the Healthcare Effectiveness Data and Information Set, patient experience ratings on a standardized Consumer Assessment of Healthcare Providers and Systems survey, as well as consumer access, utilization management, quality assurance, provider credentialing, complaints and appeals, network adequacy and access, and patient information programs by any entity recognized by the Secretary for the accreditation of health insurance issuers or plans (so long as any such entity has transparent and rigorous methodological and scoring criteria); or

(ii) receive such accreditation within a period established by an Exchange for such ac-

1 creditation that is applicable to all qualified
2 health plans;
3 (E) implement a quality improvement
4 strategy described in subsection (g)(1);
5 (F) utilize a uniform enrollment form that
6 qualified individuals and qualified employers
7 may use (either electronically or on paper) in
8 enrolling in qualified health plans offered
9 through such Exchange, and that takes into ac-
10 count criteria that the National Association of
11 Insurance Commissioners develops and submits
12 to the Secretary;
13 (G) utilize the standard format established
14 for presenting health benefits plan options; and
15 (H) provide information to enrollees and
16 prospective enrollees, and to each Exchange in
17 which the plan is offered, on any quality meas-
18 ures for health plan performance endorsed
19 under section 399JJ of the Public Health Serv-
20 ice Act, as applicable.
21 (2) RULE OF CONSTRUCTION.—Nothing in
22 paragraph (1)(C) shall be construed to require a
23 qualified health plan to contract with a provider de-
24 scribed in such paragraph if such provider refuses to

1 accept the generally applicable payment rates of
2 such plan.

3 (3) RATING SYSTEM.—The Secretary shall de-
4 velop a rating system that would rate qualified
5 health plans offered through an Exchange in each
6 benefits level on the basis of the relative quality and
7 price. The Exchange shall include the quality rating
8 in the information provided to individuals and em-
9 ployers through the Internet portal established
10 under paragraph (4).

11 (4) INTERNET PORTALS.—The Secretary
12 shall—

13 (A) continue to operate, maintain, and up-
14 date the Internet portal developed under section
15 1103(a) and to assist States in developing and
16 maintaining their own such portal; and

17 (B) make available for use by Exchanges a
18 model template for an Internet portal that may
19 be used to direct qualified individuals and quali-
20 fied employers to qualified health plans, to as-
21 sist such individuals and employers in deter-
22 mining whether they are eligible to participate
23 in an Exchange or eligible for a premium tax
24 credit or cost-sharing reduction, and to present
25 standardized information (including quality rat-

1 ings) regarding qualified health plans offered
2 through an Exchange to assist consumers in
3 making easy health insurance choices.
4 Such template shall include, with respect to each
5 qualified health plan offered through the Exchange
6 in each rating area, access to the uniform outline of
7 coverage the plan is required to provide under sec-
8 tion 2716 of the Public Health Service Act and to
9 a copy of the plan's written policy.
10 (5) ENROLLMENT PERIODS.—The Secretary
11 shall require an Exchange to provide for—
12 (A) an initial open enrollment, as deter-
13 mined by the Secretary (such determination to
14 be made not later than July 1, 2012);
15 (B) annual open enrollment periods, as de-
16 termined by the Secretary for calendar years
17 after the initial enrollment period;
18 (C) special enrollment periods specified in
19 section 9801 of the Internal Revenue Code of
20 1986 and other special enrollment periods
21 under circumstances similar to such periods
22 under part D of title XVIII of the Social Secu-
23 rity Act; and

1 (D) special monthly enrollment periods for
2 Indians (as defined in section 4 of the Indian
3 Health Care Improvement Act).
4 (d) REQUIREMENTS.—
5 (1) IN GENERAL.—An Exchange shall be a gov-
6 ernmental agency or nonprofit entity that is estab-
7 lished by a State.
8 (2) OFFERING OF COVERAGE.—
9 (A) IN GENERAL.—An Exchange shall
10 make available qualified health plans to quali-
11 fied individuals and qualified employers.
12 (B) LIMITATION.—
13 (i) IN GENERAL.—An Exchange may
14 not make available any health plan that is
15 not a qualified health plan.
16 (ii) OFFERING OF STAND-ALONE DEN-
17 TAL BENEFITS.—Each Exchange within a
18 State shall allow an issuer of a plan that
19 only provides limited scope dental benefits
20 meeting the requirements of section
21 9832(c)(2)(A) of the Internal Revenue
22 Code of 1986 to offer the plan through the
23 Exchange (either separately or in conjunc-
24 tion with a qualified health plan) if the
25 plan provides pediatric dental benefits

1 meeting the requirements of section
2 1302(b)(1)(J)).
3 (3) RULES RELATING TO ADDITIONAL RE-
4 QUIRED BENEFITS.—
5 (A) IN GENERAL.—Except as provided in
6 subparagraph (B), an Exchange may make
7 available a qualified health plan notwith-
8 standing any provision of law that may require
9 benefits other than the essential health benefits
10 specified under section 1302(b).
11 (B) STATES MAY REQUIRE ADDITIONAL
12 BENEFITS.—
13 (i) IN GENERAL.—Subject to the re-
14 quirements of clause (ii), a State may re-
15 quire that a qualified health plan offered
16 in such State offer benefits in addition to
17 the essential health benefits specified
18 under section 1302(b).
19 (ii) STATE MUST ASSUME COST.—A
20 State shall make payments to or on behalf
21 of an individual eligible for the premium
22 tax credit under section 36B of the Inter-
23 nal Revenue Code of 1986 and any cost-
24 sharing reduction under section 1402 to
25 defray the cost to the individual of any ad-

1 ditional benefits described in clause (i)
2 which are not eligible for such credit or re-
3 duction under section 36B(b)(3)(D) of
4 such Code and section 1402(c)(4).
5 (4) FUNCTIONS.—An Exchange shall, at a min-
6 imum—
7 (A) implement procedures for the certifi-
8 cation, recertification, and decertification, con-
9 sistent with guidelines developed by the Sec-
10 retary under subsection (c), of health plans as
11 qualified health plans;
12 (B) provide for the operation of a toll-free
13 telephone hotline to respond to requests for as-
14 sistance;
15 (C) maintain an Internet website through
16 which enrollees and prospective enrollees of
17 qualified health plans may obtain standardized
18 comparative information on such plans;
19 (D) assign a rating to each qualified health
20 plan offered through such Exchange in accord-
21 ance with the criteria developed by the Sec-
22 retary under subsection (c)(3);
23 (E) utilize a standardized format for pre-
24 senting health benefits plan options in the Ex-
25 change, including the use of the uniform outline

of coverage established under section 2715 of the Public Health Service Act;

(F) in accordance with section 1413, inform individuals of eligibility requirements for the medicaid program under title XIX of the Social Security Act, the CHIP program under title XXI of such Act, or any applicable State or local public program and if through screening of the application by the Exchange, the Exchange determines that such individuals are eligible for any such program, enroll such individuals in such program;

(G) establish and make available by electronic means a calculator to determine the actual cost of coverage after the application of any premium tax credit under section 36B of the Internal Revenue Code of 1986 and any cost-sharing reduction under section 1402;

(H) subject to section 1411, grant a certification attesting that, for purposes of the individual responsibility penalty under section 5000A of the Internal Revenue Code of 1986, an individual is exempt from the individual requirement or from the penalty imposed by such section because—

1 (i) there is no affordable qualified
2 health plan available through the Ex-
3 change, or the individual's employer, cov-
4 ering the individual; or
5 (ii) the individual meets the require-
6 ments for any other such exemption from
7 the individual responsibility requirement or
8 penalty;
9 (I) transfer to the Secretary of the Treas-
10 ury—
11 (i) a list of the individuals who are
12 issued a certification under subparagraph
13 (H), including the name and taxpayer
14 identification number of each individual;
15 (ii) the name and taxpayer identifica-
16 tion number of each individual who was an
17 employee of an employer but who was de-
18 termined to be eligible for the premium tax
19 credit under section 36B of the Internal
20 Revenue Code of 1986 because—
21 (I) the employer did not provide
22 minimum essential coverage; or
23 (II) the employer provided such
24 minimum essential coverage but it
25 was determined under section

36B(c)(2)(C) of such Code to either be unaffordable to the employee or not provide the required minimum actuarial value; and

(iii) the name and taxpayer identification number of each individual who notifies the Exchange under section 1411(b)(4) that they have changed employers and of each individual who ceases coverage under a qualified health plan during a plan year (and the effective date of such cessation);

(J) provide to each employer the name of each employee of the employer described in subparagraph (I)(ii) who ceases coverage under a qualified health plan during a plan year (and the effective date of such cessation); and

(K) establish the Navigator program described in subsection (i).

(5) FUNDING LIMITATIONS.—

(A) NO FEDERAL FUNDS FOR CONTINUED OPERATIONS.—In establishing an Exchange under this section, the State shall ensure that such Exchange is self-sustaining beginning on January 1, 2015, including allowing the Exchange to charge assessments or user fees to

1 participating health insurance issuers, or to
2 otherwise generate funding, to support its oper-
3 ations.
4 (B) PROHIBITING WASTEFUL USE OF
5 FUNDS.—In carrying out activities under this
6 subsection, an Exchange shall not utilize any
7 funds intended for the administrative and oper-
8 ational expenses of the Exchange for staff re-
9 treats, promotional giveaways, excessive execu-
10 tive compensation, or promotion of Federal or
11 State legislative and regulatory modifications.
12 (6) CONSULTATION.—An Exchange shall con-
13 sult with stakeholders relevant to carrying out the
14 activities under this section, including—
15 (A) health care consumers who are enroll-
16 ees in qualified health plans;
17 (B) individuals and entities with experience
18 in facilitating enrollment in qualified health
19 plans;
20 (C) representatives of small businesses and
21 self-employed individuals;
22 (D) State Medicaid offices; and
23 (E) advocates for enrolling hard to reach
24 populations.

1 (7) PUBLICATION OF COSTS.—An Exchange
2 shall publish the average costs of licensing, regu-
3 latory fees, and any other payments required by the
4 Exchange, and the administrative costs of such Ex-
5 change, on an Internet website to educate consumers
6 on such costs. Such information shall also include
7 monies lost to waste, fraud, and abuse.
8 (e) CERTIFICATION.—
9 (1) IN GENERAL.—An Exchange may certify a
10 health plan as a qualified health plan if—
11 (A) such health plan meets the require-
12 ments for certification as promulgated by the
13 Secretary under subsection (c)(1); and
14 (B) the Exchange determines that making
15 available such health plan through such Ex-
16 change is in the interests of qualified individ-
17 uals and qualified employers in the State or
18 States in which such Exchange operates, except
19 that the Exchange may not exclude a health
20 plan—
21 (i) on the basis that such plan is a
22 fee-for-service plan;
23 (ii) through the imposition of pre-
24 mium price controls; or

1 (iii) on the basis that the plan pro-
2 vides treatments necessary to prevent pa-
3 tients' deaths in circumstances the Ex-
4 change determines are inappropriate or too
5 costly.
6 (2) PREMIUM CONSIDERATIONS.—The Ex-
7 change shall require health plans seeking certifi-
8 cation as qualified health plans to submit a justifica-
9 tion for any premium increase prior to implementa-
10 tion of the increase. Such plans shall prominently
11 post such information on their websites. The Ex-
12 change may take this information, and the informa-
13 tion and the recommendations provided to the Ex-
14 change by the State under section 2794(b)(1) of the
15 Public Health Service Act (relating to patterns or
16 practices of excessive or unjustified premium in-
17 creases), into consideration when determining wheth-
18 er to make such health plan available through the
19 Exchange. The Exchange shall take into account any
20 excess of premium growth outside the Exchange as
21 compared to the rate of such growth inside the Ex-
22 change, including information reported by the
23 States.
24 (f) FLEXIBILITY.—

1 (1) REGIONAL OR OTHER INTERSTATE EX-
2 CHANGES.—An Exchange may operate in more than
3 one State if—
4 (A) each State in which such Exchange op-
5 erates permits such operation; and
6 (B) the Secretary approves such regional
7 or interstate Exchange.
8 (2) SUBSIDIARY EXCHANGES.—A State may es-
9 tablish one or more subsidiary Exchanges if—
10 (A) each such Exchange serves a geo-
11 graphically distinct area; and
12 (B) the area served by each such Exchange
13 is at least as large as a rating area described
14 in section 2701(a) of the Public Health Service
15 Act.
16 (3) AUTHORITY TO CONTRACT.—
17 (A) IN GENERAL.—A State may elect to
18 authorize an Exchange established by the State
19 under this section to enter into an agreement
20 with an eligible entity to carry out 1 or more
21 responsibilities of the Exchange.
22 (B) ELIGIBLE ENTITY.—In this para-
23 graph, the term ''eligible entity'' means—
24 (i) a person—

1 (I) incorporated under, and sub-
2 ject to the laws of, 1 or more States;
3 (II) that has demonstrated expe-
4 rience on a State or regional basis in
5 the individual and small group health
6 insurance markets and in benefits cov-
7 erage; and
8 (III) that is not a health insur-
9 ance issuer or that is treated under
10 subsection (a) or (b) of section 52 of
11 the Internal Revenue Code of 1986 as
12 a member of the same controlled
13 group of corporations (or under com-
14 mon control with) as a health insur-
15 ance issuer; or
16 (ii) the State medicaid agency under
17 title XIX of the Social Security Act.
18 (g) REWARDING QUALITY THROUGH MARKET-
19 BASED INCENTIVES.—
20 (1) STRATEGY DESCRIBED.—A strategy de-
21 scribed in this paragraph is a payment structure
22 that provides increased reimbursement or other in-
23 centives for—
24 (A) improving health outcomes through the
25 implementation of activities that shall include

1 quality reporting, effective case management,
2 care coordination, chronic disease management,
3 medication and care compliance initiatives, in-
4 cluding through the use of the medical home
5 model, for treatment or services under the plan
6 or coverage;
7 (B) the implementation of activities to pre-
8 vent hospital readmissions through a com-
9 prehensive program for hospital discharge that
10 includes patient-centered education and coun-
11 seling, comprehensive discharge planning, and
12 post discharge reinforcement by an appropriate
13 health care professional;
14 (C) the implementation of activities to im-
15 prove patient safety and reduce medical errors
16 through the appropriate use of best clinical
17 practices, evidence based medicine, and health
18 information technology under the plan or cov-
19 erage; and
20 (D) the implementation of wellness and
21 health promotion activities.
22 (2) GUIDELINES.—The Secretary, in consulta-
23 tion with experts in health care quality and stake-
24 holders, shall develop guidelines concerning the mat-
25 ters described in paragraph (1).

1 (3) REQUIREMENTS.—The guidelines developed
2 under paragraph (2) shall require the periodic re-
3 porting to the applicable Exchange of the activities
4 that a qualified health plan has conducted to imple-
5 ment a strategy described in paragraph (1).
6 (h) QUALITY IMPROVEMENT.—
7 (1) ENHANCING PATIENT SAFETY.—Beginning
8 on January 1, 2015, a qualified health plan may
9 contract with—
10 (A) a hospital with greater than 50 beds
11 only if such hospital—
12 (i) utilizes a patient safety evaluation
13 system as described in part C of title IX
14 of the Public Health Service Act; and
15 (ii) implements a mechanism to en-
16 sure that each patient receives a com-
17 prehensive program for hospital discharge
18 that includes patient-centered education
19 and counseling, comprehensive discharge
20 planning, and post discharge reinforcement
21 by an appropriate health care professional;
22 or
23 (B) a health care provider only if such pro-
24 vider implements such mechanisms to improve

1 health care quality as the Secretary may by reg-
2 ulation require.
3 (2) EXCEPTIONS.—The Secretary may establish
4 reasonable exceptions to the requirements described
5 in paragraph (1).
6 (3) ADJUSTMENT.—The Secretary may by reg-
7 ulation adjust the number of beds described in para-
8 graph (1)(A).
9 (i) NAVIGATORS.—
10 (1) IN GENERAL.—An Exchange shall establish
11 a program under which it awards grants to entities
12 described in paragraph (2) to carry out the duties
13 described in paragraph (3).
14 (2) ELIGIBILITY.—
15 (A) IN GENERAL.—To be eligible to receive
16 a grant under paragraph (1), an entity shall
17 demonstrate to the Exchange involved that the
18 entity has existing relationships, or could read-
19 ily establish relationships, with employers and
20 employees, consumers (including uninsured and
21 underinsured consumers), or self-employed indi-
22 viduals likely to be qualified to enroll in a quali-
23 fied health plan.
24 (B) TYPES.—Entities described in sub-
25 paragraph (A) may include trade, industry, and

1 professional associations, commercial fishing in-
2 dustry organizations, ranching and farming or-
3 ganizations, community and consumer-focused
4 nonprofit groups, chambers of commerce,
5 unions, small business development centers,
6 other licensed insurance agents and brokers,
7 and other entities that—
8 (i) are capable of carrying out the du-
9 ties described in paragraph (3);
10 (ii) meet the standards described in
11 paragraph (4); and
12 (iii) provide information consistent
13 with the standards developed under para-
14 graph (5).
15 (3) DUTIES.—An entity that serves as a navi-
16 gator under a grant under this subsection shall—
17 (A) conduct public education activities to
18 raise awareness of the availability of qualified
19 health plans;
20 (B) distribute fair and impartial informa-
21 tion concerning enrollment in qualified health
22 plans, and the availability of premium tax cred-
23 its under section 36B of the Internal Revenue
24 Code of 1986 and cost-sharing reductions under
25 section 1402;

1 (C) facilitate enrollment in qualified health
2 plans;
3 (D) provide referrals to any applicable of-
4 fice of health insurance consumer assistance or
5 health insurance ombudsman established under
6 section 2793 of the Public Health Service Act,
7 or any other appropriate State agency or agen-
8 cies, for any enrollee with a grievance, com-
9 plaint, or question regarding their health plan,
10 coverage, or a determination under such plan or
11 coverage; and
12 (E) provide information in a manner that
13 is culturally and linguistically appropriate to
14 the needs of the population being served by the
15 Exchange or Exchanges.
16 (4) STANDARDS.—
17 (A) IN GENERAL.—The Secretary shall es-
18 tablish standards for navigators under this sub-
19 section, including provisions to ensure that any
20 private or public entity that is selected as a
21 navigator is qualified, and licensed if appro-
22 priate, to engage in the navigator activities de-
23 scribed in this subsection and to avoid conflicts
24 of interest. Under such standards, a navigator
25 shall not—

(i) be a health insurance issuer; or

(ii) receive any consideration directly or indirectly from any health insurance issuer in connection with the enrollment of any qualified individuals or employees of a qualified employer in a qualified health plan.

(5) FAIR AND IMPARTIAL INFORMATION AND SERVICES.—The Secretary, in collaboration with States, shall develop standards to ensure that information made available by navigators is fair, accurate, and impartial.

(6) FUNDING.—Grants under this subsection shall be made from the operational funds of the Exchange and not Federal funds received by the State to establish the Exchange.

(j) APPLICABILITY OF MENTAL HEALTH PARITY.—Section 2726 of the Public Health Service Act shall apply to qualified health plans in the same manner and to the same extent as such section applies to health insurance issuers and group health plans.

(k) CONFLICT.—An Exchange may not establish rules that conflict with or prevent the application of regulations promulgated by the Secretary under this subtitle.

SEC. 1312. CONSUMER CHOICE.

(a) CHOICE.—

(1) QUALIFIED INDIVIDUALS.—A qualified individual may enroll in any qualified health plan available to such individual.

(2) QUALIFIED EMPLOYERS.—

(A) EMPLOYER MAY SPECIFY LEVEL.—A qualified employer may provide support for coverage of employees under a qualified health plan by selecting any level of coverage under section 1302(d) to be made available to employees through an Exchange.

(B) EMPLOYEE MAY CHOOSE PLANS WITHIN A LEVEL.—Each employee of a qualified employer that elects a level of coverage under subparagraph (A) may choose to enroll in a qualified health plan that offers coverage at that level.

(b) PAYMENT OF PREMIUMS BY QUALIFIED INDIVIDUALS.—A qualified individual enrolled in any qualified health plan may pay any applicable premium owed by such individual to the health insurance issuer issuing such qualified health plan.

(c) SINGLE RISK POOL.—

(1) INDIVIDUAL MARKET.—A health insurance issuer shall consider all enrollees in all health plans

1 (other than grandfathered health plans) offered by
2 such issuer in the individual market, including those
3 enrollees who do not enroll in such plans through
4 the Exchange, to be members of a single risk pool.
5 (2) SMALL GROUP MARKET.—A health insur-
6 ance issuer shall consider all enrollees in all health
7 plans (other than grandfathered health plans) of-
8 fered by such issuer in the small group market, in-
9 cluding those enrollees who do not enroll in such
10 plans through the Exchange, to be members of a
11 single risk pool.
12 (3) MERGER OF MARKETS.—A State may re-
13 quire the individual and small group insurance mar-
14 kets within a State to be merged if the State deter-
15 mines appropriate.
16 (4) STATE LAW.—A State law requiring grand-
17 fathered health plans to be included in a pool de-
18 scribed in paragraph (1) or (2) shall not apply.
19 (d) EMPOWERING CONSUMER CHOICE.—
20 (1) CONTINUED OPERATION OF MARKET OUT-
21 SIDE EXCHANGES.—Nothing in this title shall be
22 construed to prohibit—
23 (A) a health insurance issuer from offering
24 outside of an Exchange a health plan to a
25 qualified individual or qualified employer; and

1 (B) a qualified individual from enrolling in,
2 or a qualified employer from selecting for its
3 employees, a health plan offered outside of an
4 Exchange.
5 (2) CONTINUED OPERATION OF STATE BENEFIT
6 REQUIREMENTS.—Nothing in this title shall be con-
7 strued to terminate, abridge, or limit the operation
8 of any requirement under State law with respect to
9 any policy or plan that is offered outside of an Ex-
10 change to offer benefits.
11 (3) VOLUNTARY NATURE OF AN EXCHANGE.—
12 (A) CHOICE TO ENROLL OR NOT TO EN-
13 ROLL.—Nothing in this title shall be construed
14 to restrict the choice of a qualified individual to
15 enroll or not to enroll in a qualified health plan
16 or to participate in an Exchange.
17 (B) PROHIBITION AGAINST COMPELLED
18 ENROLLMENT.—Nothing in this title shall be
19 construed to compel an individual to enroll in a
20 qualified health plan or to participate in an Ex-
21 change.
22 (C) INDIVIDUALS ALLOWED TO ENROLL IN
23 ANY PLAN.—A qualified individual may enroll
24 in any qualified health plan, except that in the
25 case of a catastrophic plan described in section

1302(e), a qualified individual may enroll in the plan only if the individual is eligible to enroll in the plan under section 1302(e)(2).

(D) MEMBERS OF CONGRESS IN THE EXCHANGE.—

(i) REQUIREMENT.—Notwithstanding any other provision of law, after the effective date of this subtitle, the only health plans that the Federal Government may make available to Members of Congress and congressional staff with respect to their service as a Member of Congress or congressional staff shall be health plans that are—

(I) created under this Act (or an amendment made by this Act); or

(II) offered through an Exchange established under this Act (or an amendment made by this Act).

(ii) DEFINITIONS.—In this section:

(I) MEMBER OF CONGRESS.—The term ''Member of Congress'' means any member of the House of Representatives or the Senate.

1 (II) CONGRESSIONAL STAFF.—
2 The term ''congressional staff'' means
3 all full-time and part-time employees
4 employed by the official office of a
5 Member of Congress, whether in
6 Washington, DC or outside of Wash-
7 ington, DC.
8 (4) NO PENALTY FOR TRANSFERRING TO MIN-
9 IMUM ESSENTIAL COVERAGE OUTSIDE EXCHANGE.—
10 An Exchange, or a qualified health plan offered
11 through an Exchange, shall not impose any penalty
12 or other fee on an individual who cancels enrollment
13 in a plan because the individual becomes eligible for
14 minimum essential coverage (as defined in section
15 5000A(f) of the Internal Revenue Code of 1986
16 without regard to paragraph (1)(C) or (D) thereof)
17 or such coverage becomes affordable (within the
18 meaning of section 36B(c)(2)(C) of such Code).
19 (e) ENROLLMENT THROUGH AGENTS OR BRO-
20 KERS.—The Secretary shall establish procedures under
21 which a State may allow agents or brokers—
22 (1) to enroll individuals in any qualified health
23 plans in the individual or small group market as
24 soon as the plan is offered through an Exchange in
25 the State; and

(2) to assist individuals in applying for premium tax credits and cost-sharing reductions for plans sold through an Exchange.

Such procedures may include the establishment of rate schedules for broker commissions paid by health benefits plans offered through an exchange.

(f) QUALIFIED INDIVIDUALS AND EMPLOYERS; ACCESS LIMITED TO CITIZENS AND LAWFUL RESIDENTS.—

(1) QUALIFIED INDIVIDUALS.—In this title:

(A) IN GENERAL.—The term ''qualified individual'' means, with respect to an Exchange, an individual who—

(i) is seeking to enroll in a qualified health plan in the individual market offered through the Exchange; and

(ii) resides in the State that established the Exchange (except with respect to territorial agreements under section 1312(f)).

(B) INCARCERATED INDIVIDUALS EXCLUDED.—An individual shall not be treated as a qualified individual if, at the time of enrollment, the individual is incarcerated, other than incarceration pending the disposition of charges.

1 (2) QUALIFIED EMPLOYER.—In this title:
2 (A) IN GENERAL.—The term ''qualified
3 employer'' means a small employer that elects
4 to make all full-time employees of such em-
5 ployer eligible for 1 or more qualified health
6 plans offered in the small group market
7 through an Exchange that offers qualified
8 health plans.
9 (B) EXTENSION TO LARGE GROUPS.—
10 (i) IN GENERAL.—Beginning in 2017,
11 each State may allow issuers of health in-
12 surance coverage in the large group mar-
13 ket in the State to offer qualified health
14 plans in such market through an Ex-
15 change. Nothing in this subparagraph shall
16 be construed as requiring the issuer to
17 offer such plans through an Exchange.
18 (ii) LARGE EMPLOYERS ELIGIBLE.—If
19 a State under clause (i) allows issuers to
20 offer qualified health plans in the large
21 group market through an Exchange, the
22 term ''qualified employer'' shall include a
23 large employer that elects to make all full-
24 time employees of such employer eligible
25 for 1 or more qualified health plans offered

in the large group market through the Exchange.

(3) ACCESS LIMITED TO LAWFUL RESIDENTS.—If an individual is not, or is not reasonably expected to be for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States, the individual shall not be treated as a qualified individual and may not be covered under a qualified health plan in the individual market that is offered through an Exchange.

SEC. 1313. FINANCIAL INTEGRITY.

(a) ACCOUNTING FOR EXPENDITURES.—

(1) IN GENERAL.—An Exchange shall keep an accurate accounting of all activities, receipts, and expenditures and shall annually submit to the Secretary a report concerning such accountings.

(2) INVESTIGATIONS.—The Secretary, in coordination with the Inspector General of the Department of Health and Human Services, may investigate the affairs of an Exchange, may examine the properties and records of an Exchange, and may require periodic reports in relation to activities undertaken by an Exchange. An Exchange shall fully co-

1 operate in any investigation conducted under this
2 paragraph.
3 (3) AUDITS.—An Exchange shall be subject to
4 annual audits by the Secretary.
5 (4) PATTERN OF ABUSE.—If the Secretary de-
6 termines that an Exchange or a State has engaged
7 in serious misconduct with respect to compliance
8 with the requirements of, or carrying out of activi-
9 ties required under, this title, the Secretary may re-
10 scind from payments otherwise due to such State in-
11 volved under this or any other Act administered by
12 the Secretary an amount not to exceed 1 percent of
13 such payments per year until corrective actions are
14 taken by the State that are determined to be ade-
15 quate by the Secretary.
16 (5) PROTECTIONS AGAINST FRAUD AND
17 ABUSE.—With respect to activities carried out under
18 this title, the Secretary shall provide for the efficient
19 and non-discriminatory administration of Exchange
20 activities and implement any measure or procedure
21 that—
22 (A) the Secretary determines is appro-
23 priate to reduce fraud and abuse in the admin-
24 istration of this title; and

1 (B) the Secretary has authority to imple-
2 ment under this title or any other Act.
3 (6) APPLICATION OF THE FALSE CLAIMS
4 ACT.—
5 (A) IN GENERAL.—Payments made by,
6 through, or in connection with an Exchange are
7 subject to the False Claims Act (31 U.S.C.
8 3729 et seq.) if those payments include any
9 Federal funds. Compliance with the require-
10 ments of this Act concerning eligibility for a
11 health insurance issuer to participate in the Ex-
12 change shall be a material condition of an
13 issuer's entitlement to receive payments, includ-
14 ing payments of premium tax credits and cost-
15 sharing reductions, through the Exchange.
16 (B) DAMAGES.—Notwithstanding para-
17 graph (1) of section 3729(a) of title 31, United
18 States Code, and subject to paragraph (2) of
19 such section, the civil penalty assessed under
20 the False Claims Act on any person found liable
21 under such Act as described in subparagraph
22 (A) shall be increased by not less than 3 times
23 and not more than 6 times the amount of dam-
24 ages which the Government sustains because of
25 the act of that person.

1 (b) GAO OVERSIGHT.—Not later than 5 years after
2 the first date on which Exchanges are required to be oper-
3 ational under this title, the Comptroller General shall con-
4 duct an ongoing study of Exchange activities and the en-
5 rollees in qualified health plans offered through Ex-
6 changes. Such study shall review—
7 (1) the operations and administration of Ex-
8 changes, including surveys and reports of qualified
9 health plans offered through Exchanges and on the
10 experience of such plans (including data on enrollees
11 in Exchanges and individuals purchasing health in-
12 surance coverage outside of Exchanges), the ex-
13 penses of Exchanges, claims statistics relating to
14 qualified health plans, complaints data relating to
15 such plans, and the manner in which Exchanges
16 meet their goals;
17 (2) any significant observations regarding the
18 utilization and adoption of Exchanges;
19 (3) where appropriate, recommendations for im-
20 provements in the operations or policies of Ex-
21 changes; and
22 (4) how many physicians, by area and specialty,
23 are not taking or accepting new patients enrolled in
24 Federal Government health care programs, and the

adequacy of provider networks of Federal Government health care programs.

PART III—STATE FLEXIBILITY RELATING TO EXCHANGES

SEC. 1321. STATE FLEXIBILITY IN OPERATION AND ENFORCEMENT OF EXCHANGES AND RELATED REQUIREMENTS.

(a) ESTABLISHMENT OF STANDARDS.—

(1) IN GENERAL.—The Secretary shall, as soon as practicable after the date of enactment of this Act, issue regulations setting standards for meeting the requirements under this title, and the amendments made by this title, with respect to—

(A) the establishment and operation of Exchanges (including SHOP Exchanges);

(B) the offering of qualified health plans through such Exchanges;

(C) the establishment of the reinsurance and risk adjustment programs under part V; and

(D) such other requirements as the Secretary determines appropriate.

The preceding sentence shall not apply to standards for requirements under subtitles A and C (and the amendments made by such subtitles) for which the

1 Secretary issues regulations under the Public Health
2 Service Act.
3 (2) CONSULTATION.—In issuing the regulations
4 under paragraph (1), the Secretary shall consult
5 with the National Association of Insurance Commis-
6 sioners and its members and with health insurance
7 issuers, consumer organizations, and such other in-
8 dividuals as the Secretary selects in a manner de-
9 signed to ensure balanced representation among in-
10 terested parties.
11 (b) STATE ACTION.—Each State that elects, at such
12 time and in such manner as the Secretary may prescribe,
13 to apply the requirements described in subsection (a)
14 shall, not later than January 1, 2014, adopt and have in
15 effect—
16 (1) the Federal standards established under
17 subsection (a); or
18 (2) a State law or regulation that the Secretary
19 determines implements the standards within the
20 State.
21 (c) FAILURE TO ESTABLISH EXCHANGE OR IMPLE-
22 MENT REQUIREMENTS.—
23 (1) IN GENERAL.—If—
24 (A) a State is not an electing State under
25 subsection (b); or

(B) the Secretary determines, on or before January 1, 2013, that an electing State—

(i) will not have any required Exchange operational by January 1, 2014; or

(ii) has not taken the actions the Secretary determines necessary to implement—

(I) the other requirements set forth in the standards under subsection (a); or

(II) the requirements set forth in subtitles A and C and the amendments made by such subtitles;

the Secretary shall (directly or through agreement with a not-for-profit entity) establish and operate such Exchange within the State and the Secretary shall take such actions as are necessary to implement such other requirements.

(2) ENFORCEMENT AUTHORITY.—The provisions of section 2736(b) of the Public Health Services Act shall apply to the enforcement under paragraph (1) of requirements of subsection (a)(1) (without regard to any limitation on the application of those provisions to group health plans).

1 (d) NO INTERFERENCE WITH STATE REGULATORY
2 AUTHORITY.—Nothing in this title shall be construed to
3 preempt any State law that does not prevent the applica-
4 tion of the provisions of this title.

5 (e) PRESUMPTION FOR CERTAIN STATE-OPERATED
6 EXCHANGES.—

7 (1) IN GENERAL.—In the case of a State oper-
8 ating an Exchange before January 1, 2010, and
9 which has insured a percentage of its population not
10 less than the percentage of the population projected
11 to be covered nationally after the implementation of
12 this Act, that seeks to operate an Exchange under
13 this section, the Secretary shall presume that such
14 Exchange meets the standards under this section
15 unless the Secretary determines, after completion of
16 the process established under paragraph (2), that
17 the Exchange does not comply with such standards.

18 (2) PROCESS.—The Secretary shall establish a
19 process to work with a State described in paragraph
20 (1) to provide assistance necessary to assist the
21 State's Exchange in coming into compliance with the
22 standards for approval under this section.

SEC. 1322. FEDERAL PROGRAM TO ASSIST ESTABLISHMENT AND OPERATION OF NONPROFIT, MEMBER-RUN HEALTH INSURANCE ISSUERS.

(a) ESTABLISHMENT OF PROGRAM.—

(1) IN GENERAL.—The Secretary shall establish a program to carry out the purposes of this section to be known as the Consumer Operated and Oriented Plan (CO-OP) program.

(2) PURPOSE.—It is the purpose of the CO-OP program to foster the creation of qualified nonprofit health insurance issuers to offer qualified health plans in the individual and small group markets in the States in which the issuers are licensed to offer such plans.

(b) LOANS AND GRANTS UNDER THE CO-OP PROGRAM.—

(1) IN GENERAL.—The Secretary shall provide through the CO-OP program for the awarding to persons applying to become qualified nonprofit health insurance issuers of—

(A) loans to provide assistance to such person in meeting its start-up costs; and

(B) grants to provide assistance to such person in meeting any solvency requirements of States in which the person seeks to be licensed to issue qualified health plans.

1 (2) REQUIREMENTS FOR AWARDING LOANS AND
2 GRANTS.—
3 (A) IN GENERAL.—In awarding loans and
4 grants under the CO-OP program, the Sec-
5 retary shall—
6 (i) take into account the recommenda-
7 tions of the advisory board established
8 under paragraph (3);
9 (ii) give priority to applicants that will
10 offer qualified health plans on a Statewide
11 basis, will utilize integrated care models,
12 and have significant private support; and
13 (iii) ensure that there is sufficient
14 funding to establish at least 1 qualified
15 nonprofit health insurance issuer in each
16 State, except that nothing in this clause
17 shall prohibit the Secretary from funding
18 the establishment of multiple qualified
19 nonprofit health insurance issuers in any
20 State if the funding is sufficient to do so.
21 (B) STATES WITHOUT ISSUERS IN PRO-
22 GRAM.—If no health insurance issuer applies to
23 be a qualified nonprofit health insurance issuer
24 within a State, the Secretary may use amounts
25 appropriated under this section for the award-

1 ing of grants to encourage the establishment of
2 a qualified nonprofit health insurance issuer
3 within the State or the expansion of a qualified
4 nonprofit health insurance issuer from another
5 State to the State.
6 (C) AGREEMENT.—
7 (i) IN GENERAL.—The Secretary shall
8 require any person receiving a loan or
9 grant under the CO-OP program to enter
10 into an agreement with the Secretary
11 which requires such person to meet (and to
12 continue to meet)—
13 (I) any requirement under this
14 section for such person to be treated
15 as a qualified nonprofit health insur-
16 ance issuer; and
17 (II) any requirements contained
18 in the agreement for such person to
19 receive such loan or grant.
20 (ii) RESTRICTIONS ON USE OF FED-
21 ERAL FUNDS.—The agreement shall in-
22 clude a requirement that no portion of the
23 funds made available by any loan or grant
24 under this section may be used—

(I) for carrying on propaganda, or otherwise attempting, to influence legislation; or

(II) for marketing.

Nothing in this clause shall be construed to allow a person to take any action prohibited by section 501(c)(29) of the Internal Revenue Code of 1986.

(iii) FAILURE TO MEET REQUIREMENTS.—If the Secretary determines that a person has failed to meet any requirement described in clause (i) or (ii) and has failed to correct such failure within a reasonable period of time of when the person first knows (or reasonably should have known) of such failure, such person shall repay to the Secretary an amount equal to the sum of—

(I) 110 percent of the aggregate amount of loans and grants received under this section; plus

(II) interest on the aggregate amount of loans and grants received under this section for the period the loans or grants were outstanding.

The Secretary shall notify the Secretary of the Treasury of any determination under this section of a failure that results in the termination of an issuer's tax-exempt status under section 501(c)(29) of such Code.

(D) TIME FOR AWARDING LOANS AND GRANTS.—The Secretary shall not later than July 1, 2013, award the loans and grants under the CO-OP program and begin the distribution of amounts awarded under such loans and grants.

(3) ADVISORY BOARD.—

(A) IN GENERAL.—The advisory board under this paragraph shall consist of 15 members appointed by the Comptroller General of the United States from among individuals with qualifications described in section 1805(c)(2) of the Social Security Act.

(B) RULES RELATING TO APPOINTMENTS.—

(i) STANDARDS.—Any individual appointed under subparagraph (A) shall meet ethics and conflict of interest standards protecting against insurance industry involvement and interference.

(ii) ORIGINAL APPOINTMENTS.—The original appointment of board members under subparagraph (A)(ii) shall be made no later than 3 months after the date of enactment of this Act.

(C) VACANCY.—Any vacancy on the advisory board shall be filled in the same manner as the original appointment.

(D) PAY AND REIMBURSEMENT.—

(i) NO COMPENSATION FOR MEMBERS OF ADVISORY BOARD.—Except as provided in clause (ii), a member of the advisory board may not receive pay, allowances, or benefits by reason of their service on the board.

(ii) TRAVEL EXPENSES.—Each member shall receive travel expenses, including per diem in lieu of subsistence under subchapter I of chapter 57 of title 5, United States Code.

(E) APPLICATION OF FACA.—The Federal Advisory Committee Act (5 U.S.C. App.) shall apply to the advisory board, except that section 14 of such Act shall not apply.

1 (F) TERMINATION.—The advisory board
2 shall terminate on the earlier of the date that
3 it completes its duties under this section or De-
4 cember 31, 2015.
5 (c) QUALIFIED NONPROFIT HEALTH INSURANCE
6 ISSUER.—For purposes of this section—
7 (1) IN GENERAL.—The term ''qualified non-
8 profit health insurance issuer'' means a health insur-
9 ance issuer that is an organization—
10 (A) that is organized under State law as a
11 nonprofit, member corporation;
12 (B) substantially all of the activities of
13 which consist of the issuance of qualified health
14 plans in the individual and small group markets
15 in each State in which it is licensed to issue
16 such plans; and
17 (C) that meets the other requirements of
18 this subsection.
19 (2) CERTAIN ORGANIZATIONS PROHIBITED.—
20 An organization shall not be treated as a qualified
21 nonprofit health insurance issuer if—
22 (A) the organization or a related entity (or
23 any predecessor of either) was a health insur-
24 ance issuer on July 16, 2009; or

1 (B) the organization is sponsored by a
2 State or local government, any political subdivi-
3 sion thereof, or any instrumentality of such
4 government or political subdivision.
5 (3) GOVERNANCE REQUIREMENTS.—An organi-
6 zation shall not be treated as a qualified nonprofit
7 health insurance issuer unless—
8 (A) the governance of the organization is
9 subject to a majority vote of its members;
10 (B) its governing documents incorporate
11 ethics and conflict of interest standards pro-
12 tecting against insurance industry involvement
13 and interference; and
14 (C) as provided in regulations promulgated
15 by the Secretary, the organization is required to
16 operate with a strong consumer focus, including
17 timeliness, responsiveness, and accountability to
18 members.
19 (4) PROFITS INURE TO BENEFIT OF MEM-
20 BERS.—An organization shall not be treated as a
21 qualified nonprofit health insurance issuer unless
22 any profits made by the organization are required to
23 be used to lower premiums, to improve benefits, or
24 for other programs intended to improve the quality
25 of health care delivered to its members.

1 (5) COMPLIANCE WITH STATE INSURANCE
2 LAWS.—An organization shall not be treated as a
3 qualified nonprofit health insurance issuer unless the
4 organization meets all the requirements that other
5 issuers of qualified health plans are required to meet
6 in any State where the issuer offers a qualified
7 health plan, including solvency and licensure require-
8 ments, rules on payments to providers, and compli-
9 ance with network adequacy rules, rate and form fil-
10 ing rules, any applicable State premium assessments
11 and any other State law described in section
12 1324(b).
13 (6) COORDINATION WITH STATE INSURANCE
14 REFORMS.—An organization shall not be treated as
15 a qualified nonprofit health insurance issuer unless
16 the organization does not offer a health plan in a
17 State until that State has in effect (or the Secretary
18 has implemented for the State) the market reforms
19 required by part A of title XXVII of the Public
20 Health Service Act (as amended by subtitles A and
21 C of this Act).
22 (d) ESTABLISHMENT OF PRIVATE PURCHASING
23 COUNCIL.—
24 (1) IN GENERAL.—Qualified nonprofit health
25 insurance issuers participating in the CO-OP pro-

1 gram under this section may establish a private pur-
2 chasing council to enter into collective purchasing
3 arrangements for items and services that increase
4 administrative and other cost efficiencies, including
5 claims administration, administrative services, health
6 information technology, and actuarial services.

7 (2) COUNCIL MAY NOT SET PAYMENT RATES.—
8 The private purchasing council established under
9 paragraph (1) shall not set payment rates for health
10 care facilities or providers participating in health in-
11 surance coverage provided by qualified nonprofit
12 health insurance issuers.

13 (3) CONTINUED APPLICATION OF ANTITRUST
14 LAWS.—

15 (A) IN GENERAL.—Nothing in this section
16 shall be construed to limit the application of the
17 antitrust laws to any private purchasing council
18 (whether or not established under this sub-
19 section) or to any qualified nonprofit health in-
20 surance issuer participating in such a council.

21 (B) ANTITRUST LAWS.—For purposes of
22 this subparagraph, the term ''antitrust laws''
23 has the meaning given the term in subsection
24 (a) of the first section of the Clayton Act (15
25 U.S.C. 12(a)). Such term also includes section

5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent that such section 5 applies to unfair methods of competition.

(e) LIMITATION ON PARTICIPATION.—No representative of any Federal, State, or local government (or of any political subdivision or instrumentality thereof), and no representative of a person described in subsection (c)(2)(A), may serve on the board of directors of a qualified nonprofit health insurance issuer or with a private purchasing council established under subsection (d).

(f) LIMITATIONS ON SECRETARY.—

(1) IN GENERAL.—The Secretary shall not—

(A) participate in any negotiations between 1 or more qualified nonprofit health insurance issuers (or a private purchasing council established under subsection (d)) and any health care facilities or providers, including any drug manufacturer, pharmacy, or hospital; and

(B) establish or maintain a price structure for reimbursement of any health benefits covered by such issuers.

(2) COMPETITION.—Nothing in this section shall be construed as authorizing the Secretary to interfere with the competitive nature of providing

1 health benefits through qualified nonprofit health in-
2 surance issuers.
3 (g) APPROPRIATIONS.—There are hereby appro-
4 priated, out of any funds in the Treasury not otherwise
5 appropriated, $6,000,000,000 to carry out this section.
6 (h) TAX EXEMPTION FOR QUALIFIED NONPROFIT
7 HEALTH INSURANCE ISSUER.—
8 (1) IN GENERAL.—Section 501(c) of the Inter-
9 nal Revenue Code of 1986 (relating to list of exempt
10 organizations) is amended by adding at the end the
11 following:
12 ''(29) CO-OP HEALTH INSURANCE ISSUERS.—
13 ''(A) IN GENERAL.—A qualified nonprofit
14 health insurance issuer (within the meaning of
15 section 1322 of the Patient Protection and Af-
16 fordable Care Act) which has received a loan or
17 grant under the CO-OP program under such
18 section, but only with respect to periods for
19 which the issuer is in compliance with the re-
20 quirements of such section and any agreement
21 with respect to the loan or grant.
22 ''(B) CONDITIONS FOR EXEMPTION.—Sub-
23 paragraph (A) shall apply to an organization
24 only if—

"(i) the organization has given notice to the Secretary, in such manner as the Secretary may by regulations prescribe, that it is applying for recognition of its status under this paragraph,

"(ii) except as provided in section 1322(c)(4) of the Patient Protection and Affordable Care Act, no part of the net earnings of which inures to the benefit of any private shareholder or individual,

"(iii) no substantial part of the activities of which is carrying on propaganda, or otherwise attempting, to influence legislation, and

"(iv) the organization does not participate in, or intervene in (including the publishing or distributing of statements), any political campaign on behalf of (or in opposition to) any candidate for public office.".

(2) ADDITIONAL REPORTING REQUIREMENT.—Section 6033 of such Code (relating to returns by exempt organizations) is amended by redesignating subsection (m) as subsection (n) and by inserting after subsection (l) the following:

1 "(m) ADDITIONAL INFORMATION REQUIRED FROM
2 CO-OP INSURERS.—An organization described in section
3 501(c)(29) shall include on the return required under sub-
4 section (a) the following information:
5 "(1) The amount of the reserves required by
6 each State in which the organization is licensed to
7 issue qualified health plans.
8 "(2) The amount of reserves on hand.".
9 (3) APPLICATION OF TAX ON EXCESS BENEFIT
10 TRANSACTIONS.—Section 4958(e)(1) of such Code
11 (defining applicable tax-exempt organization) is
12 amended by striking "paragraph (3) or (4)" and in-
13 serting "paragraph (3), (4), or (29)".
14 (i) GAO STUDY AND REPORT.—
15 (1) STUDY.—The Comptroller General of the
16 General Accountability Office shall conduct an ongo-
17 ing study on competition and market concentration
18 in the health insurance market in the United States
19 after the implementation of the reforms in such
20 market under the provisions of, and the amendments
21 made by, this Act. Such study shall include an anal-
22 ysis of new issuers of health insurance in such mar-
23 ket.
24 (2) REPORT.—The Comptroller General shall,
25 not later than December 31 of each even-numbered

1 year (beginning with 2014), report to the appro-
2 priate committees of the Congress the results of the
3 study conducted under paragraph (1), including any
4 recommendations for administrative or legislative
5 changes the Comptroller General determines nec-
6 essary or appropriate to increase competition in the
7 health insurance market.

8 **SEC. 1323. COMMUNITY HEALTH INSURANCE OPTION.**

9 (a) VOLUNTARY NATURE.—

10 (1) NO REQUIREMENT FOR HEALTH CARE PRO-
11 VIDERS TO PARTICIPATE.—Nothing in this section
12 shall be construed to require a health care provider
13 to participate in a community health insurance op-
14 tion, or to impose any penalty for non-participation.

15 (2) NO REQUIREMENT FOR INDIVIDUALS TO
16 JOIN.—Nothing in this section shall be construed to
17 require an individual to participate in a community
18 health insurance option, or to impose any penalty for
19 non-participation.

20 (3) STATE OPT OUT.—

21 (A) IN GENERAL.—A State may elect to
22 prohibit Exchanges in such State from offering
23 a community health insurance option if such
24 State enacts a law to provide for such prohibi-
25 tion.

1 (B) TERMINATION OF OPT OUT.—A State
2 may repeal a law described in subparagraph (A)
3 and provide for the offering of such an option
4 through the Exchange.
5 (b) ESTABLISHMENT OF COMMUNITY HEALTH IN-
6 SURANCE OPTION.—
7 (1) ESTABLISHMENT.—The Secretary shall es-
8 tablish a community health insurance option to
9 offer, through the Exchanges established under this
10 title (other than Exchanges in States that elect to
11 opt out as provided for in subsection (a)(3)), health
12 care coverage that provides value, choice, competi-
13 tion, and stability of affordable, high quality cov-
14 erage throughout the United States.
15 (2) COMMUNITY HEALTH INSURANCE OP-
16 TION.—In this section, the term ''community health
17 insurance option'' means health insurance coverage
18 that—
19 (A) except as specifically provided for in
20 this section, complies with the requirements for
21 being a qualified health plan;
22 (B) provides high value for the premium
23 charged;

(C) reduces administrative costs and promotes administrative simplification for beneficiaries;

(D) promotes high quality clinical care;

(E) provides high quality customer service to beneficiaries;

(F) offers a sufficient choice of providers; and

(G) complies with State laws (if any), except as otherwise provided for in this title, relating to the laws described in section 1324(b).

(3) ESSENTIAL HEALTH BENEFITS.—

(A) GENERAL RULE.—Except as provided in subparagraph (B), a community health insurance option offered under this section shall provide coverage only for the essential health benefits described in section 1302(b).

(B) STATES MAY OFFER ADDITIONAL BENEFITS.—Nothing in this section shall preclude a State from requiring that benefits in addition to the essential health benefits required under subparagraph (A) be provided to enrollees of a community health insurance option offered in such State.

(C) CREDITS.—

1 (i) IN GENERAL.—An individual en-
2 rolled in a community health insurance op-
3 tion under this section shall be eligible for
4 credits under section 36B of the Internal
5 Revenue Code of 1986 in the same manner
6 as an individual who is enrolled in a quali-
7 fied health plan.
8 (ii) NO ADDITIONAL FEDERAL
9 COST.—A requirement by a State under
10 subparagraph (B) that benefits in addition
11 to the essential health benefits required
12 under subparagraph (A) be provided to en-
13 rollees of a community health insurance
14 option shall not affect the amount of a pre-
15 mium tax credit provided under section
16 36B of the Internal Revenue Code of 1986
17 with respect to such plan.
18 (D) STATE MUST ASSUME COST.—A State
19 shall make payments to or on behalf of an eligi-
20 ble individual to defray the cost of any addi-
21 tional benefits described in subparagraph (B).
22 (E) ENSURING ACCESS TO ALL SERV-
23 ICES.—Nothing in this Act shall prohibit an in-
24 dividual enrolled in a community health insur-
25 ance option from paying out-of-pocket the full

1 cost of any item or service not included as an
2 essential health benefit or otherwise covered as
3 a benefit by a health plan. Nothing in subpara-
4 graph (B) shall prohibit any type of medical
5 provider from accepting an out-of-pocket pay-
6 ment from an individual enrolled in a commu-
7 nity health insurance option for a service other-
8 wise not included as an essential health benefit.
9 (F) PROTECTING ACCESS TO END OF LIFE
10 CARE.—A community health insurance option
11 offered under this section shall be prohibited
12 from limiting access to end of life care.
13 (4) COST SHARING.—A community health in-
14 surance option shall offer coverage at each of the
15 levels of coverage described in section 1302(d).
16 (5) PREMIUMS.—
17 (A) PREMIUMS SUFFICIENT TO COVER
18 COSTS.—The Secretary shall establish geo-
19 graphically adjusted premium rates in an
20 amount sufficient to cover expected costs (in-
21 cluding claims and administrative costs) using
22 methods in general use by qualified health
23 plans.
24 (B) APPLICABLE RULES.—The provisions
25 of title XXVII of the Public Health Service Act

relating to premiums shall apply to community health insurance options under this section, including modified community rating provisions under section 2701 of such Act.

(C) COLLECTION OF DATA.—The Secretary shall collect data as necessary to set premium rates under subparagraph (A).

(D) NATIONAL POOLING.—Notwithstanding any other provision of law, the Secretary may treat all enrollees in community health insurance options as members of a single pool.

(E) CONTINGENCY MARGIN.—In establishing premium rates under subparagraph (A), the Secretary shall include an appropriate amount for a contingency margin.

(6) REIMBURSEMENT RATES.—

(A) NEGOTIATED RATES.—The Secretary shall negotiate rates for the reimbursement of health care providers for benefits covered under a community health insurance option.

(B) LIMITATION.—The rates described in subparagraph (A) shall not be higher, in aggregate, than the average reimbursement rates

1 paid by health insurance issuers offering quali-
2 fied health plans through the Exchange.
3 (C) INNOVATION.—Subject to the limits
4 contained in subparagraph (A), a State Advi-
5 sory Council established or designated under
6 subsection (d) may develop or encourage the
7 use of innovative payment policies that promote
8 quality, efficiency and savings to consumers.
9 (7) SOLVENCY AND CONSUMER PROTECTION.—
10 (A) SOLVENCY.—The Secretary shall es-
11 tablish a Federal solvency standard to be ap-
12 plied with respect to a community health insur-
13 ance option. A community health insurance op-
14 tion shall also be subject to the solvency stand-
15 ard of each State in which such community
16 health insurance option is offered.
17 (B) MINIMUM REQUIRED.—In establishing
18 the standard described under subparagraph
19 (A), the Secretary shall require a reserve fund
20 that shall be equal to at least the dollar value
21 of the incurred but not reported claims of a
22 community health insurance option.
23 (C) CONSUMER PROTECTIONS.—The con-
24 sumer protection laws of a State shall apply to
25 a community health insurance option.

1 (8) REQUIREMENTS ESTABLISHED IN PARTNER-
2 SHIP WITH INSURANCE COMMISSIONERS.—
3 (A) IN GENERAL.—The Secretary, in col-
4 laboration with the National Association of In-
5 surance Commissioners (in this paragraph re-
6 ferred to as the ''NAIC''), may promulgate reg-
7 ulations to establish additional requirements for
8 a community health insurance option.
9 (B) APPLICABILITY.—Any requirement
10 promulgated under subparagraph (A) shall be
11 applicable to such option beginning 90 days
12 after the date on which the regulation involved
13 becomes final.
14 (c) START-UP FUND.—
15 (1) ESTABLISHMENT OF FUND.—
16 (A) IN GENERAL.—There is established in
17 the Treasury of the United States a trust fund
18 to be known as the ''Health Benefit Plan Start-
19 Up Fund'' (referred to in this section as the
20 ''Start-Up Fund''), that shall consist of such
21 amounts as may be appropriated or credited to
22 the Start-Up Fund as provided for in this sub-
23 section to provide loans for the initial oper-
24 ations of a community health insurance option.

1 Such amounts shall remain available until ex-
2 pended.
3 (B) FUNDING.—There is hereby appro-
4 priated to the Start-Up Fund, out of any mon-
5 eys in the Treasury not otherwise appropriated
6 an amount requested by the Secretary of
7 Health and Human Services as necessary to—
8 (i) pay the start-up costs associated
9 with the initial operations of a community
10 health insurance option; and
11 (ii) pay the costs of making payments
12 on claims submitted during the period that
13 is not more than 90 days from the date on
14 which such option is offered.
15 (2) USE OF START-UP FUND.—The Secretary
16 shall use amounts contained in the Start-Up Fund
17 to make payments (subject to the repayment re-
18 quirements in paragraph (4)) for the purposes de-
19 scribed in paragraph (1)(B).
20 (3) PASS THROUGH OF REBATES.—The Sec-
21 retary may establish procedures for reducing the
22 amount of payments to a contracting administrator
23 to take into account any rebates or price conces-
24 sions.
25 (4) REPAYMENT.—

1 (A) IN GENERAL.—A community health in-
2 surance option shall be required to repay the
3 Secretary of the Treasury (on such terms as the
4 Secretary may require) for any payments made
5 under paragraph (1)(B) by the date that is not
6 later than 9 years after the date on which the
7 payment is made. The Secretary may require
8 the payment of interest with respect to such re-
9 payments at rates that do not exceed the mar-
10 ket interest rate (as determined by the Sec-
11 retary).
12 (B) SANCTIONS IN CASE OF FOR-PROFIT
13 CONVERSION.—In any case in which the Sec-
14 retary enters into a contract with a qualified
15 entity for the offering of a community health
16 insurance option and such entity is determined
17 to be a for-profit entity by the Secretary, such
18 entity shall be—
19 (i) immediately liable to the Secretary
20 for any payments received by such entity
21 from the Start-Up Fund; and
22 (ii) permanently ineligible to offer a
23 qualified health plan.
24 (d) STATE ADVISORY COUNCIL.—

1 (1) ESTABLISHMENT.—A State (other than a
2 State that elects to opt out as provided for in sub-
3 section (a)(3)) shall establish or designate a public
4 or non-profit private entity to serve as the State Ad-
5 visory Council to provide recommendations to the
6 Secretary on the operations and policies of a com-
7 munity health insurance option in the State. Such
8 Council shall provide recommendations on at least
9 the following:
10 (A) policies and procedures to integrate
11 quality improvement and cost containment
12 mechanisms into the health care delivery sys-
13 tem;
14 (B) mechanisms to facilitate public aware-
15 ness of the availability of a community health
16 insurance option; and
17 (C) alternative payment structures under a
18 community health insurance option for health
19 care providers that encourage quality improve-
20 ment and cost control.
21 (2) MEMBERS.—The members of the State Ad-
22 visory Council shall be representatives of the public
23 and shall include health care consumers and pro-
24 viders.

1 (3) APPLICABILITY OF RECOMMENDATIONS.—
2 The Secretary may apply the recommendations of a
3 State Advisory Council to a community health insur-
4 ance option in that State, in any other State, or in
5 all States.
6 (e) AUTHORITY TO CONTRACT; TERMS OF CON-
7 TRACT.—
8 (1) AUTHORITY.—
9 (A) IN GENERAL.—The Secretary may
10 enter into a contract or contracts with one or
11 more qualified entities for the purpose of per-
12 forming administrative functions (including
13 functions described in subsection (a)(4) of sec-
14 tion 1874A of the Social Security Act) with re-
15 spect to a community health insurance option in
16 the same manner as the Secretary may enter
17 into contracts under subsection (a)(1) of such
18 section. The Secretary shall have the same au-
19 thority with respect to a community health in-
20 surance option under this section as the Sec-
21 retary has under subsections (a)(1) and (b) of
22 section 1874A of the Social Security Act with
23 respect to title XVIII of such Act.
24 (B) REQUIREMENTS APPLY.—If the Sec-
25 retary enters into a contract with a qualified

1 entity to offer a community health insurance
2 option, under such contract such entity—
3 (i) shall meet the criteria established
4 under paragraph (2); and
5 (ii) shall receive an administrative fee
6 under paragraph (7).
7 (C) LIMITATION.—Contracts under this
8 subsection shall not involve the transfer of in-
9 surance risk to the contracting administrator.
10 (D) REFERENCE.—An entity with which
11 the Secretary has entered into a contract under
12 this paragraph shall be referred to as a ''con-
13 tracting administrator''.
14 (2) QUALIFIED ENTITY.—To be qualified to be
15 selected by the Secretary to offer a community
16 health insurance option, an entity shall—
17 (A) meet the criteria established under sec-
18 tion 1874A(a)(2) of the Social Security Act;
19 (B) be a nonprofit entity for purposes of
20 offering such option;
21 (C) meet the solvency standards applicable
22 under subsection (b)(7);
23 (D) be eligible to offer health insurance or
24 health benefits coverage;

(E) meet quality standards specified by the Secretary;

(F) have in place effective procedures to control fraud, abuse, and waste; and

(G) meet such other requirements as the Secretary may impose.

Procedures described under subparagraph (F) shall include the implementation of procedures to use beneficiary identifiers to identify individuals entitled to benefits so that such an individual's social security account number is not used, and shall also include procedures for the use of technology (including front-end, prepayment intelligent data-matching technology similar to that used by hedge funds, investment funds, and banks) to provide real-time data analysis of claims for payment under this title to identify and investigate unusual billing or order practices under this title that could indicate fraud or abuse.

(3) TERM.—A contract provided for under paragraph (1) shall be for a term of at least 5 years but not more than 10 years, as determined by the Secretary. At the end of each such term, the Secretary shall conduct a competitive bidding process for the purposes of renewing existing contracts or

selecting new qualified entities with which to enter into contracts under such paragraph.

(4) LIMITATION.—A contract may not be renewed under this subsection unless the Secretary determines that the contracting administrator has met performance requirements established by the Secretary in the areas described in paragraph (7)(B).

(5) AUDITS.—The Inspector General shall conduct periodic audits with respect to contracting administrators under this subsection to ensure that the administrator involved is in compliance with this section.

(6) REVOCATION.—A contract awarded under this subsection shall be revoked by the Secretary, upon the recommendation of the Inspector General, only after notice to the contracting administrator involved and an opportunity for a hearing. The Secretary may revoke such contract if the Secretary determines that such administrator has engaged in fraud, deception, waste, abuse of power, negligence, mismanagement of taxpayer dollars, or gross mismanagement. An entity that has had a contract revoked under this paragraph shall not be qualified to enter into a subsequent contract under this subsection.

(7) FEE FOR ADMINISTRATION.—

(A) IN GENERAL.—The Secretary shall pay the contracting administrator a fee for the management, administration, and delivery of the benefits under this section.

(B) REQUIREMENT FOR HIGH QUALITY ADMINISTRATION.—The Secretary may increase the fee described in subparagraph (A) by not more than 10 percent, or reduce the fee described in subparagraph (A) by not more than 50 percent, based on the extent to which the contracting administrator, in the determination of the Secretary, meets performance requirements established by the Secretary, in at least the following areas:

(i) Maintaining low premium costs and low cost sharing requirements, provided that such requirements are consistent with section 1302.

(ii) Reducing administrative costs and promoting administrative simplification for beneficiaries.

(iii) Promoting high quality clinical care.

1 (iv) Providing high quality customer
2 service to beneficiaries.
3 (C) NON-RENEWAL.—The Secretary may
4 not renew a contract to offer a community
5 health insurance option under this section with
6 any contracting entity that has been assessed
7 more than one reduction under subparagraph
8 (B) during the contract period.
9 (8) LIMITATION.—Notwithstanding the terms
10 of a contract under this subsection, the Secretary
11 shall negotiate the reimbursement rates for purposes
12 of subsection (b)(6).
13 (f) REPORT BY HHS AND INSOLVENCY WARN-
14 INGS.—
15 (1) IN GENERAL.—On an annual basis, the Sec-
16 retary shall conduct a study on the solvency of a
17 community health insurance option and submit to
18 Congress a report describing the results of such
19 study.
20 (2) RESULT.—If, in any year, the result of the
21 study under paragraph (1) is that a community
22 health insurance option is insolvent, such result shall
23 be treated as a community health insurance option
24 solvency warning.
25 (3) SUBMISSION OF PLAN AND PROCEDURE.—

1 (A) IN GENERAL.—If there is a community
2 health insurance option solvency warning under
3 paragraph (2) made in a year, the President
4 shall submit to Congress, within the 15-day pe-
5 riod beginning on the date of the budget sub-
6 mission to Congress under section 1105(a) of
7 title 31, United States Code, for the succeeding
8 year, proposed legislation to respond to such
9 warning.
10 (B) PROCEDURE.—In the case of a legisla-
11 tive proposal submitted by the President pursu-
12 ant to subparagraph (A), such proposal shall be
13 considered by Congress using the same proce-
14 dures described under sections 803 and 804 of
15 the Medicare Prescription Drug, Improvement,
16 and Modernization Act of 2003 that shall be
17 used for a medicare funding warning.
18 (g) MARKETING PARITY.—In a facility controlled by
19 the Federal Government, or by a State, where marketing
20 or promotional materials related to a community health
21 insurance option are made available to the public, making
22 available marketing or promotional materials relating to
23 private health insurance plans shall not be prohibited.
24 Such materials include informational pamphlets, guide-

1 books, enrollment forms, or other materials determined
2 reasonable for display.

3 (h) AUTHORIZATION OF APPROPRIATIONS.—There is
4 authorized to be appropriated such sums as may be nec-
5 essary to carry out this section.

6 **SEC. 1324. LEVEL PLAYING FIELD.**

7 (a) IN GENERAL.—Notwithstanding any other provi-
8 sion of law, any health insurance coverage offered by a
9 private health insurance issuer shall not be subject to any
10 Federal or State law described in subsection (b) if a quali-
11 fied health plan offered under the Consumer Operated and
12 Oriented Plan program under section 1322, a community
13 health insurance option under section 1323, or a nation-
14 wide qualified health plan under section 1333(b), is not
15 subject to such law.

16 (b) LAWS DESCRIBED.—The Federal and State laws
17 described in this subsection are those Federal and State
18 laws relating to—

19 (1) guaranteed renewal;

20 (2) rating;

21 (3) preexisting conditions;

22 (4) non-discrimination;

23 (5) quality improvement and reporting;

24 (6) fraud and abuse;

25 (7) solvency and financial requirements;

(8) market conduct;

(9) prompt payment;

(10) appeals and grievances;

(11) privacy and confidentiality;

(12) licensure; and

(13) benefit plan material or information.

PART IV—STATE FLEXIBILITY TO ESTABLISH ALTERNATIVE PROGRAMS

SEC. 1331. STATE FLEXIBILITY TO ESTABLISH BASIC HEALTH PROGRAMS FOR LOW-INCOME INDIVIDUALS NOT ELIGIBLE FOR MEDICAID.

(a) ESTABLISHMENT OF PROGRAM.—

(1) IN GENERAL.—The Secretary shall establish a basic health program meeting the requirements of this section under which a State may enter into contracts to offer 1 or more standard health plans providing at least the essential health benefits described in section 1302(b) to eligible individuals in lieu of offering such individuals coverage through an Exchange.

(2) CERTIFICATIONS AS TO BENEFIT COVERAGE AND COSTS.—Such program shall provide that a State may not establish a basic health program under this section unless the State establishes to the

1 satisfaction of the Secretary, and the Secretary cer-
2 tifies, that—
3 (A) in the case of an eligible individual en-
4 rolled in a standard health plan offered through
5 the program, the State provides—
6 (i) that the amount of the monthly
7 premium an eligible individual is required
8 to pay for coverage under the standard
9 health plan for the individual and the indi-
10 vidual's dependents does not exceed the
11 amount of the monthly premium that the
12 eligible individual would have been required
13 to pay (in the rating area in which the in-
14 dividual resides) if the individual had en-
15 rolled in the applicable second lowest cost
16 silver plan (as defined in section
17 36B(b)(3)(B) of the Internal Revenue
18 Code of 1986) offered to the individual
19 through an Exchange; and
20 (ii) that the cost-sharing an eligible
21 individual is required to pay under the
22 standard health plan does not exceed—
23 (I) the cost-sharing required
24 under a platinum plan in the case of
25 an eligible individual with household

1 income not in excess of 150 percent of
2 the poverty line for the size of the
3 family involved; and
4 (II) the cost-sharing required
5 under a gold plan in the case of an el-
6 igible individual not described in sub-
7 clause (I); and
8 (B) the benefits provided under the stand-
9 ard health plans offered through the program
10 cover at least the essential health benefits de-
11 scribed in section 1302(b).
12 For purposes of subparagraph (A)(i), the amount of
13 the monthly premium an individual is required to
14 pay under either the standard health plan or the ap-
15 plicable second lowest cost silver plan shall be deter-
16 mined after reduction for any premium tax credits
17 and cost-sharing reductions allowable with respect to
18 either plan.
19 (b) STANDARD HEALTH PLAN.—In this section, the
20 term ''standard heath plan'' means a health benefits plan
21 that the State contracts with under this section—
22 (1) under which the only individuals eligible to
23 enroll are eligible individuals;
24 (2) that provides at least the essential health
25 benefits described in section 1302(b); and

1 (3) in the case of a plan that provides health
2 insurance coverage offered by a health insurance
3 issuer, that has a medical loss ratio of at least 85
4 percent.
5 (c) CONTRACTING PROCESS.—
6 (1) IN GENERAL.—A State basic health pro-
7 gram shall establish a competitive process for enter-
8 ing into contracts with standard health plans under
9 subsection (a), including negotiation of premiums
10 and cost-sharing and negotiation of benefits in addi-
11 tion to the essential health benefits described in sec-
12 tion 1302(b).
13 (2) SPECIFIC ITEMS TO BE CONSIDERED.—A
14 State shall, as part of its competitive process under
15 paragraph (1), include at least the following:
16 (A) INNOVATION.—Negotiation with
17 offerors of a standard health plan for the inclu-
18 sion of innovative features in the plan, includ-
19 ing—
20 (i) care coordination and care man-
21 agement for enrollees, especially for those
22 with chronic health conditions;
23 (ii) incentives for use of preventive
24 services; and

1 (iii) the establishment of relationships
2 between providers and patients that maxi-
3 mize patient involvement in health care de-
4 cision-making, including providing incen-
5 tives for appropriate utilization under the
6 plan.
7 (B) HEALTH AND RESOURCE DIF-
8 FERENCES.—Consideration of, and the making
9 of suitable allowances for, differences in health
10 care needs of enrollees and differences in local
11 availability of, and access to, health care pro-
12 viders. Nothing in this subparagraph shall be
13 construed as allowing discrimination on the
14 basis of pre-existing conditions or other health
15 status-related factors.
16 (C) MANAGED CARE.—Contracting with
17 managed care systems, or with systems that
18 offer as many of the attributes of managed care
19 as are feasible in the local health care market.
20 (D) PERFORMANCE MEASURES.—Estab-
21 lishing specific performance measures and
22 standards for issuers of standard health plans
23 that focus on quality of care and improved
24 health outcomes, requiring such plans to report
25 to the State with respect to the measures and

1 standards, and making the performance and
2 quality information available to enrollees in a
3 useful form.
4 (3) ENHANCED AVAILABILITY.—
5 (A) MULTIPLE PLANS.—A State shall, to
6 the maximum extent feasible, seek to make
7 multiple standard health plans available to eligi-
8 ble individuals within a State to ensure individ-
9 uals have a choice of such plans.
10 (B) REGIONAL COMPACTS.—A State may
11 negotiate a regional compact with other States
12 to include coverage of eligible individuals in all
13 such States in agreements with issuers of
14 standard health plans.
15 (4) COORDINATION WITH OTHER STATE PRO-
16 GRAMS.—A State shall seek to coordinate the admin-
17 istration of, and provision of benefits under, its pro-
18 gram under this section with the State medicaid pro-
19 gram under title XIX of the Social Security Act, the
20 State child health plan under title XXI of such Act,
21 and other State-administered health programs to
22 maximize the efficiency of such programs and to im-
23 prove the continuity of care.
24 (d) TRANSFER OF FUNDS TO STATES.—

1 (1) IN GENERAL.—If the Secretary determines
2 that a State electing the application of this section
3 meets the requirements of the program established
4 under subsection (a), the Secretary shall transfer to
5 the State for each fiscal year for which 1 or more
6 standard health plans are operating within the State
7 the amount determined under paragraph (3).
8 (2) USE OF FUNDS.—A State shall establish a
9 trust for the deposit of the amounts received under
10 paragraph (1) and amounts in the trust fund shall
11 only be used to reduce the premiums and cost-shar-
12 ing of, or to provide additional benefits for, eligible
13 individuals enrolled in standard health plans within
14 the State. Amounts in the trust fund, and expendi-
15 tures of such amounts, shall not be included in de-
16 termining the amount of any non-Federal funds for
17 purposes of meeting any matching or expenditure re-
18 quirement of any federally-funded program.
19 (3) AMOUNT OF PAYMENT.—
20 (A) SECRETARIAL DETERMINATION.—
21 (i) IN GENERAL.—The amount deter-
22 mined under this paragraph for any fiscal
23 year is the amount the Secretary deter-
24 mines is equal to 85 percent of the pre-
25 mium tax credits under section 36B of the

1 Internal Revenue Code of 1986, and the
2 cost-sharing reductions under section
3 1402, that would have been provided for
4 the fiscal year to eligible individuals en-
5 rolled in standard health plans in the State
6 if such eligible individuals were allowed to
7 enroll in qualified health plans through an
8 Exchange established under this subtitle.
9 (ii) SPECIFIC REQUIREMENTS.—The
10 Secretary shall make the determination
11 under clause (i) on a per enrollee basis and
12 shall take into account all relevant factors
13 necessary to determine the value of the
14 premium tax credits and cost-sharing re-
15 ductions that would have been provided to
16 eligible individuals described in clause (i),
17 including the age and income of the en-
18 rollee, whether the enrollment is for self-
19 only or family coverage, geographic dif-
20 ferences in average spending for health
21 care across rating areas, the health status
22 of the enrollee for purposes of determining
23 risk adjustment payments and reinsurance
24 payments that would have been made if
25 the enrollee had enrolled in a qualified

1 health plan through an Exchange, and
2 whether any reconciliation of the credit or
3 cost-sharing reductions would have oc-
4 curred if the enrollee had been so enrolled.
5 This determination shall take into consid-
6 eration the experience of other States with
7 respect to participation in an Exchange
8 and such credits and reductions provided
9 to residents of the other States, with a spe-
10 cial focus on enrollees with income below
11 200 percent of poverty.
12 (iii) CERTIFICATION.—The Chief Ac-
13 tuary of the Centers for Medicare & Med-
14 icaid Services, in consultation with the Of-
15 fice of Tax Analysis of the Department of
16 the Treasury, shall certify whether the
17 methodology used to make determinations
18 under this subparagraph, and such deter-
19 minations, meet the requirements of clause
20 (ii). Such certifications shall be based on
21 sufficient data from the State and from
22 comparable States about their experience
23 with programs created by this Act.
24 (B) CORRECTIONS.—The Secretary shall
25 adjust the payment for any fiscal year to reflect

1 any error in the determinations under subpara-
2 graph (A) for any preceding fiscal year.
3 (4) APPLICATION OF SPECIAL RULES.—The
4 provisions of section 1303 shall apply to a State
5 basic health program, and to standard health plans
6 offered through such program, in the same manner
7 as such rules apply to qualified health plans.
8 (e) ELIGIBLE INDIVIDUAL.—
9 (1) IN GENERAL.—In this section, the term ''el-
10 igible individual'' means, with respect to any State,
11 an individual—
12 (A) who a resident of the State who is not
13 eligible to enroll in the State's medicaid pro-
14 gram under title XIX of the Social Security Act
15 for benefits that at a minimum consist of the
16 essential health benefits described in section
17 1302(b);
18 (B) whose household income exceeds 133
19 percent but does not exceed 200 percent of the
20 poverty line for the size of the family involved;
21 (C) who is not eligible for minimum essen-
22 tial coverage (as defined in section 5000A(f) of
23 the Internal Revenue Code of 1986) or is eligi-
24 ble for an employer-sponsored plan that is not

1 affordable coverage (as determined under sec-
2 tion 5000A(e)(2) of such Code); and
3 (D) who has not attained age 65 as of the
4 beginning of the plan year.
5 Such term shall not include any individual who is
6 not a qualified individual under section 1312 who is
7 eligible to be covered by a qualified health plan of-
8 fered through an Exchange.
9 (2) ELIGIBLE INDIVIDUALS MAY NOT USE EX-
10 CHANGE.—An eligible individual shall not be treated
11 as a qualified individual under section 1312 eligible
12 for enrollment in a qualified health plan offered
13 through an Exchange established under section
14 1311.
15 (f) SECRETARIAL OVERSIGHT.—The Secretary shall
16 each year conduct a review of each State program to en-
17 sure compliance with the requirements of this section, in-
18 cluding ensuring that the State program meets—
19 (1) eligibility verification requirements for par-
20 ticipation in the program;
21 (2) the requirements for use of Federal funds
22 received by the program; and
23 (3) the quality and performance standards
24 under this section.

1 (g) STANDARD HEALTH PLAN OFFERORS.—A State
2 may provide that persons eligible to offer standard health
3 plans under a basic health program established under this
4 section may include a licensed health maintenance organi-
5 zation, a licensed health insurance insurer, or a network
6 of health care providers established to offer services under
7 the program.

8 (h) DEFINITIONS.—Any term used in this section
9 which is also used in section 36B of the Internal Revenue
10 Code of 1986 shall have the meaning given such term by
11 such section.

12 **SEC. 1332. WAIVER FOR STATE INNOVATION.**

13 (a) APPLICATION.—

14 (1) IN GENERAL.—A State may apply to the
15 Secretary for the waiver of all or any requirements
16 described in paragraph (2) with respect to health in-
17 surance coverage within that State for plan years be-
18 ginning on or after January 1, 2017. Such applica-
19 tion shall—

20 (A) be filed at such time and in such man-
21 ner as the Secretary may require;

22 (B) contain such information as the Sec-
23 retary may require, including—

24 (i) a comprehensive description of the
25 State legislation and program to imple-

ment a plan meeting the requirements for a waiver under this section; and

(ii) a 10-year budget plan for such plan that is budget neutral for the Federal Government; and

(C) provide an assurance that the State has enacted the law described in subsection (b)(2).

(2) REQUIREMENTS.—The requirements described in this paragraph with respect to health insurance coverage within the State for plan years beginning on or after January 1, 2014, are as follows:

(A) Part I of subtitle D.

(B) Part II of subtitle D.

(C) Section 1402.

(D) Sections 36B, 4980H, and 5000A of the Internal Revenue Code of 1986.

(3) PASS THROUGH OF FUNDING.—With respect to a State waiver under paragraph (1), under which, due to the structure of the State plan, individuals and small employers in the State would not qualify for the premium tax credits, cost-sharing reductions, or small business credits under sections 36B of the Internal Revenue Code of 1986 or under part I of subtitle E for which they would otherwise

be eligible, the Secretary shall provide for an alternative means by which the aggregate amount of such credits or reductions that would have been paid on behalf of participants in the Exchanges established under this title had the State not received such waiver, shall be paid to the State for purposes of implementing the State plan under the waiver. Such amount shall be determined annually by the Secretary, taking into consideration the experience of other States with respect to participation in an Exchange and credits and reductions provided under such provisions to residents of the other States.

(4) WAIVER CONSIDERATION AND TRANSPARENCY.—

(A) IN GENERAL.—An application for a waiver under this section shall be considered by the Secretary in accordance with the regulations described in subparagraph (B).

(B) REGULATIONS.—Not later than 180 days after the date of enactment of this Act, the Secretary shall promulgate regulations relating to waivers under this section that provide—

(i) a process for public notice and comment at the State level, including pub-

lic hearings, sufficient to ensure a meaningful level of public input;

(ii) a process for the submission of an application that ensures the disclosure of—

(I) the provisions of law that the State involved seeks to waive; and

(II) the specific plans of the State to ensure that the waiver will be in compliance with subsection (b);

(iii) a process for providing public notice and comment after the application is received by the Secretary, that is sufficient to ensure a meaningful level of public input and that does not impose requirements that are in addition to, or duplicative of, requirements imposed under the Administrative Procedures Act, or requirements that are unreasonable or unnecessarily burdensome with respect to State compliance;

(iv) a process for the submission to the Secretary of periodic reports by the State concerning the implementation of the program under the waiver; and

(v) a process for the periodic evaluation by the Secretary of the program under the waiver.

(C) REPORT.—The Secretary shall annually report to Congress concerning actions taken by the Secretary with respect to applications for waivers under this section.

(5) COORDINATED WAIVER PROCESS.—The Secretary shall develop a process for coordinating and consolidating the State waiver processes applicable under the provisions of this section, and the existing waiver processes applicable under titles XVIII, XIX, and XXI of the Social Security Act, and any other Federal law relating to the provision of health care items or services. Such process shall permit a State to submit a single application for a waiver under any or all of such provisions.

(6) DEFINITION.—In this section, the term ''Secretary'' means—

(A) the Secretary of Health and Human Services with respect to waivers relating to the provisions described in subparagraph (A) through (C) of paragraph (2); and

(B) the Secretary of the Treasury with respect to waivers relating to the provisions described in paragraph (2)(D).

(b) GRANTING OF WAIVERS.—

(1) IN GENERAL.—The Secretary may grant a request for a waiver under subsection (a)(1) only if the Secretary determines that the State plan—

(A) will provide coverage that is at least as comprehensive as the coverage defined in section 1302(b) and offered through Exchanges established under this title as certified by Office of the Actuary of the Centers for Medicare & Medicaid Services based on sufficient data from the State and from comparable States about their experience with programs created by this Act and the provisions of this Act that would be waived;

(B) will provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable as the provisions of this title would provide;

(C) will provide coverage to at least a comparable number of its residents as the provisions of this title would provide; and

(D) will not increase the Federal deficit.

(2) REQUIREMENT TO ENACT A LAW.—

(A) IN GENERAL.—A law described in this paragraph is a State law that provides for State actions under a waiver under this section, including the implementation of the State plan under subsection (a)(1)(B).

(B) TERMINATION OF OPT OUT.—A State may repeal a law described in subparagraph (A) and terminate the authority provided under the waiver with respect to the State.

(c) SCOPE OF WAIVER.—

(1) IN GENERAL.—The Secretary shall determine the scope of a waiver of a requirement described in subsection (a)(2) granted to a State under subsection (a)(1).

(2) LIMITATION.—The Secretary may not waive under this section any Federal law or requirement that is not within the authority of the Secretary.

(d) DETERMINATIONS BY SECRETARY.—

(1) TIME FOR DETERMINATION.—The Secretary shall make a determination under subsection (a)(1) not later than 180 days after the receipt of an application from a State under such subsection.

(2) EFFECT OF DETERMINATION.—

(A) GRANTING OF WAIVERS.—If the Secretary determines to grant a waiver under subsection (a)(1), the Secretary shall notify the State involved of such determination and the terms and effectiveness of such waiver.

(B) DENIAL OF WAIVER.—If the Secretary determines a waiver should not be granted under subsection (a)(1), the Secretary shall notify the State involved, and the appropriate committees of Congress of such determination and the reasons therefore.

(e) TERM OF WAIVER.—No waiver under this section may extend over a period of longer than 5 years unless the State requests continuation of such waiver, and such request shall be deemed granted unless the Secretary, within 90 days after the date of its submission to the Secretary, either denies such request in writing or informs the State in writing with respect to any additional information which is needed in order to make a final determination with respect to the request.

SEC. 1333. PROVISIONS RELATING TO OFFERING OF PLANS IN MORE THAN ONE STATE.

(a) HEALTH CARE CHOICE COMPACTS.—

(1) IN GENERAL.—Not later than July 1, 2013, the Secretary shall, in consultation with the National

1 Association of Insurance Commissioners, issue regu-
2 lations for the creation of health care choice com-
3 pacts under which 2 or more States may enter into
4 an agreement under which—
5 (A) 1 or more qualified health plans could
6 be offered in the individual markets in all such
7 States but, except as provided in subparagraph
8 (B), only be subject to the laws and regulations
9 of the State in which the plan was written or
10 issued;
11 (B) the issuer of any qualified health plan
12 to which the compact applies—
13 (i) would continue to be subject to
14 market conduct, unfair trade practices,
15 network adequacy, and consumer protec-
16 tion standards (including standards relat-
17 ing to rating), including addressing dis-
18 putes as to the performance of the con-
19 tract, of the State in which the purchaser
20 resides;
21 (ii) would be required to be licensed in
22 each State in which it offers the plan
23 under the compact or to submit to the ju-
24 risdiction of each such State with regard to
25 the standards described in clause (i) (in-

1 cluding allowing access to records as if the
2 insurer were licensed in the State); and
3 (iii) must clearly notify consumers
4 that the policy may not be subject to all
5 the laws and regulations of the State in
6 which the purchaser resides.
7 (2) STATE AUTHORITY.—A State may not enter
8 into an agreement under this subsection unless the
9 State enacts a law after the date of the enactment
10 of this title that specifically authorizes the State to
11 enter into such agreements.
12 (3) APPROVAL OF COMPACTS.—The Secretary
13 may approve interstate health care choice compacts
14 under paragraph (1) only if the Secretary deter-
15 mines that such health care choice compact—
16 (A) will provide coverage that is at least as
17 comprehensive as the coverage defined in sec-
18 tion 1302(b) and offered through Exchanges es-
19 tablished under this title;
20 (B) will provide coverage and cost sharing
21 protections against excessive out-of-pocket
22 spending that are at least as affordable as the
23 provisions of this title would provide;

(C) will provide coverage to at least a comparable number of its residents as the provisions of this title would provide;

(D) will not increase the Federal deficit; and

(E) will not weaken enforcement of laws and regulations described in paragraph (1)(B)(i) in any State that is included in such compact.

(4) EFFECTIVE DATE.—A health care choice compact described in paragraph (1) shall not take effect before January 1, 2016.

(b) AUTHORITY FOR NATIONWIDE PLANS.—

(1) IN GENERAL.—Except as provided in paragraph (2), if an issuer (including a group of health insurance issuers affiliated either by common ownership and control or by the common use of a nationally licensed service mark) of a qualified health plan in the individual or small group market meets the requirements of this subsection (in this subsection a ''nationwide qualified health plan'')—

(A) the issuer of the plan may offer the nationwide qualified health plan in the individual or small group market in more than 1 State; and

(B) with respect to State laws mandating benefit coverage by a health plan, only the State laws of the State in which such plan is written or issued shall apply to the nationwide qualified health plan.

(2) STATE OPT-OUT.—A State may, by specific reference in a law enacted after the date of enactment of this title, provide that this subsection shall not apply to that State. Such opt-out shall be effective until such time as the State by law revokes it.

(3) PLAN REQUIREMENTS.—An issuer meets the requirements of this subsection with respect to a nationwide qualified health plan if, in the determination of the Secretary—

(A) the plan offers a benefits package that is uniform in each State in which the plan is offered and meets the requirements set forth in paragraphs (4) through (6);

(B) the issuer is licensed in each State in which it offers the plan and is subject to all requirements of State law not inconsistent with this section, including but not limited to, the standards and requirements that a State imposes that do not prevent the application of a requirement of part A of title XXVII of the

1 Public Health Service Act or a requirement of
2 this title;
3 (C) the issuer meets all requirements of
4 this title with respect to a qualified health plan,
5 including the requirement to offer the silver and
6 gold levels of the plan in each Exchange in the
7 State for the market in which the plan is of-
8 fered;
9 (D) the issuer determines the premiums
10 for the plan in any State on the basis of the
11 rating rules in effect in that State for the rat-
12 ing areas in which it is offered;
13 (E) the issuer offers the nationwide quali-
14 fied health plan in at least 60 percent of the
15 participating States in the first year in which
16 the plan is offered, 65 percent of such States
17 in the second year, 70 percent of such States in
18 the third year, 75 percent of such States in the
19 fourth year, and 80 percent of such States in
20 the fifth and subsequent years;
21 (F) the issuer shall offer the plan in par-
22 ticipating States across the country, in all geo-
23 graphic regions, and in all States that have
24 adopted adjusted community rating before the
25 date of enactment of this Act; and

1 (G) the issuer clearly notifies consumers
2 that the policy may not contain some benefits
3 otherwise mandated for plans in the State in
4 which the purchaser resides and provides a de-
5 tailed statement of the benefits offered and the
6 benefit differences in that State, in accordance
7 with rules promulgated by the Secretary.

8 (4) FORM REVIEW FOR NATIONWIDE PLANS.—
9 Notwithstanding any contrary provision of State
10 law, at least 3 months before any nationwide quali-
11 fied health plan is offered, the issuer shall file all na-
12 tionwide qualified health plan forms with the regu-
13 lator in each participating State in which the plan
14 will be offered. An issuer may appeal the disapproval
15 of a nationwide qualified health plan form to the
16 Secretary.

17 (5) APPLICABLE RULES.—The Secretary shall,
18 in consultation with the National Association of In-
19 surance Commissioners, issue rules for the offering
20 of nationwide qualified health plans under this sub-
21 section. Nationwide qualified health plans may be of-
22 fered only after such rules have taken effect.

23 (6) COVERAGE.—The Secretary shall provide
24 that the health benefits coverage provided to an indi-
25 vidual through a nationwide qualified health plan

1 under this subsection shall include at least the es-
2 sential benefits package described in section 1302.
3 (7) STATE LAW MANDATING BENEFIT COV-
4 ERAGE BY A HEALTH BENEFITS PLAN.—For the
5 purposes of this subsection, a State law mandating
6 benefit coverage by a health plan is a law that man-
7 dates health insurance coverage or the offer of
8 health insurance coverage for specific health services
9 or specific diseases. A law that mandates health in-
10 surance coverage or reimbursement for services pro-
11 vided by certain classes of providers of health care
12 services, or a law that mandates that certain classes
13 of individuals must be covered as a group or as de-
14 pendents, is not a State law mandating benefit cov-
15 erage by a health benefits plan.

16 **PART V—REINSURANCE AND RISK ADJUSTMENT**

17 **SEC. 1341. TRANSITIONAL REINSURANCE PROGRAM FOR**
18 **INDIVIDUAL AND SMALL GROUP MARKETS IN**
19 **EACH STATE.**

20 (a) IN GENERAL.—Each State shall, not later than
21 January 1, 2014—
22 (1) include in the Federal standards or State
23 law or regulation the State adopts and has in effect
24 under section 1321(b) the provisions described in
25 subsection (b); and

(2) establish (or enter into a contract with) 1 or more applicable reinsurance entities to carry out the reinsurance program under this section.

(b) MODEL REGULATION.—

(1) IN GENERAL.—In establishing the Federal standards under section 1321(a), the Secretary, in consultation with the National Association of Insurance Commissioners (the "NAIC"), shall include provisions that enable States to establish and maintain a program under which—

(A) health insurance issuers, and third party administrators on behalf of group health plans, are required to make payments to an applicable reinsurance entity for any plan year beginning in the 3-year period beginning January 1, 2014 (as specified in paragraph (3); and

(B) the applicable reinsurance entity collects payments under subparagraph (A) and uses amounts so collected to make reinsurance payments to health insurance issuers described in subparagraph (A) that cover high risk individuals in the individual market (excluding grandfathered health plans) for any plan year beginning in such 3-year period.

1 (2) HIGH-RISK INDIVIDUAL; PAYMENT
2 AMOUNTS.—The Secretary shall include the fol-
3 lowing in the provisions under paragraph (1):
4 (A) DETERMINATION OF HIGH-RISK INDI-
5 VIDUALS.—The method by which individuals
6 will be identified as high risk individuals for
7 purposes of the reinsurance program estab-
8 lished under this section. Such method shall
9 provide for identification of individuals as high-
10 risk individuals on the basis of—
11 (i) a list of at least 50 but not more
12 than 100 medical conditions that are iden-
13 tified as high-risk conditions and that may
14 be based on the identification of diagnostic
15 and procedure codes that are indicative of
16 individuals with pre-existing, high-risk con-
17 ditions; or
18 (ii) any other comparable objective
19 method of identification recommended by
20 the American Academy of Actuaries.
21 (B) PAYMENT AMOUNT.—The formula for
22 determining the amount of payments that will
23 be paid to health insurance issuers described in
24 paragraph (1)(A) that insure high-risk individ-
25 uals. Such formula shall provide for the equi-

1 table allocation of available funds through rec-
2 onciliation and may be designed—
3 (i) to provide a schedule of payments
4 that specifies the amount that will be paid
5 for each of the conditions identified under
6 subparagraph (A); or
7 (ii) to use any other comparable meth-
8 od for determining payment amounts that
9 is recommended by the American Academy
10 of Actuaries and that encourages the use
11 of care coordination and care management
12 programs for high risk conditions.
13 (3) DETERMINATION OF REQUIRED CONTRIBU-
14 TIONS.—
15 (A) IN GENERAL.—The Secretary shall in-
16 clude in the provisions under paragraph (1) the
17 method for determining the amount each health
18 insurance issuer and group health plan de-
19 scribed in paragraph (1)(A) contributing to the
20 reinsurance program under this section is re-
21 quired to contribute under such paragraph for
22 each plan year beginning in the 36-month pe-
23 riod beginning January 1, 2014. The contribu-
24 tion amount for any plan year may be based on
25 the percentage of revenue of each issuer and

1 the total costs of providing benefits to enrollees
2 in self-insured plans or on a specified amount
3 per enrollee and may be required to be paid in
4 advance or periodically throughout the plan
5 year.

6 (B) SPECIFIC REQUIREMENTS.—The meth-
7 od under this paragraph shall be designed so
8 that—

9 (i) the contribution amount for each
10 issuer proportionally reflects each issuer's
11 fully insured commercial book of business
12 for all major medical products and the
13 total value of all fees charged by the issuer
14 and the costs of coverage administered by
15 the issuer as a third party administrator;

16 (ii) the contribution amount can in-
17 clude an additional amount to fund the ad-
18 ministrative expenses of the applicable re-
19 insurance entity;

20 (iii) the aggregate contribution
21 amounts for all States shall, based on the
22 best estimates of the NAIC and without
23 regard to amounts described in clause (ii),
24 equal $10,000,000,000 for plan years be-
25 ginning in 2014, $6,000,000,000 for plan

1 years beginning 2015, and $4,000,000,000
2 for plan years beginning in 2016; and
3 (iv) in addition to the aggregate con-
4 tribution amounts under clause (iii), each
5 issuer's contribution amount for any cal-
6 endar year under clause (iii) reflects its
7 proportionate share of an additional
8 $2,000,000,000 for 2014, an additional
9 $2,000,000,000 for 2015, and an addi-
10 tional $1,000,000,000 for 2016.
11 Nothing in this subparagraph shall be con-
12 strued to preclude a State from collecting addi-
13 tional amounts from issuers on a voluntary
14 basis.
15 (4) EXPENDITURE OF FUNDS.—The provisions
16 under paragraph (1) shall provide that—
17 (A) the contribution amounts collected for
18 any calendar year may be allocated and used in
19 any of the three calendar years for which
20 amounts are collected based on the reinsurance
21 needs of a particular period or to reflect experi-
22 ence in a prior period; and
23 (B) amounts remaining unexpended as of
24 December, 2016, may be used to make pay-
25 ments under any reinsurance program of a

State in the individual market in effect in the 2-year period beginning on January 1, 2017.

Notwithstanding the preceding sentence, any contribution amounts described in paragraph (3)(B)(iv) shall be deposited into the general fund of the Treasury of the United States and may not be used for the program established under this section.

(c) APPLICABLE REINSURANCE ENTITY.—For purposes of this section—

(1) IN GENERAL.—The term ''applicable reinsurance entity'' means a not-for-profit organization—

(A) the purpose of which is to help stabilize premiums for coverage in the individual and small group markets in a State during the first 3 years of operation of an Exchange for such markets within the State when the risk of adverse selection related to new rating rules and market changes is greatest; and

(B) the duties of which shall be to carry out the reinsurance program under this section by coordinating the funding and operation of the risk-spreading mechanisms designed to implement the reinsurance program.

(2) STATE DISCRETION.—A State may have more than 1 applicable reinsurance entity to carry out the reinsurance program under this section within the State and 2 or more States may enter into agreements to provide for an applicable reinsurance entity to carry out such program in all such States.

(3) ENTITIES ARE TAX-EXEMPT.—An applicable reinsurance entity established under this section shall be exempt from taxation under chapter 1 of the Internal Revenue Code of 1986. The preceding sentence shall not apply to the tax imposed by section 511 such Code (relating to tax on unrelated business taxable income of an exempt organization).

(d) COORDINATION WITH STATE HIGH-RISK POOLS.—The State shall eliminate or modify any State high-risk pool to the extent necessary to carry out the reinsurance program established under this section. The State may coordinate the State high-risk pool with such program to the extent not inconsistent with the provisions of this section.

SEC. 1342. ESTABLISHMENT OF RISK CORRIDORS FOR PLANS IN INDIVIDUAL AND SMALL GROUP MARKETS.

(a) IN GENERAL.—The Secretary shall establish and administer a program of risk corridors for calendar years

2014, 2015, and 2016 under which a qualified health plan offered in the individual or small group market shall participate in a payment adjustment system based on the ratio of the allowable costs of the plan to the plan's aggregate premiums. Such program shall be based on the program for regional participating provider organizations under part D of title XVIII of the Social Security Act.

(b) PAYMENT METHODOLOGY.—

(1) PAYMENTS OUT.—The Secretary shall provide under the program established under subsection (a) that if—

(A) a participating plan's allowable costs for any plan year are more than 103 percent but not more than 108 percent of the target amount, the Secretary shall pay to the plan an amount equal to 50 percent of the target amount in excess of 103 percent of the target amount; and

(B) a participating plan's allowable costs for any plan year are more than 108 percent of the target amount, the Secretary shall pay to the plan an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of allowable costs in excess of 108 percent of the target amount.

(2) PAYMENTS IN.—The Secretary shall provide under the program established under subsection (a) that if—

(A) a participating plan's allowable costs for any plan year are less than 97 percent but not less than 92 percent of the target amount, the plan shall pay to the Secretary an amount equal to 50 percent of the excess of 97 percent of the target amount over the allowable costs; and

(B) a participating plan's allowable costs for any plan year are less than 92 percent of the target amount, the plan shall pay to the Secretary an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of the excess of 92 percent of the target amount over the allowable costs.

(c) DEFINITIONS.—In this section:

(1) ALLOWABLE COSTS.—

(A) IN GENERAL.—The amount of allowable costs of a plan for any year is an amount equal to the total costs (other than administrative costs) of the plan in providing benefits covered by the plan.

1 (B) REDUCTION FOR RISK ADJUSTMENT
2 AND REINSURANCE PAYMENTS.—Allowable
3 costs shall reduced by any risk adjustment and
4 reinsurance payments received under section
5 1341 and 1343.
6 (2) TARGET AMOUNT.—The target amount of a
7 plan for any year is an amount equal to the total
8 premiums (including any premium subsidies under
9 any governmental program), reduced by the adminis-
10 trative costs of the plan.

11 **SEC. 1343. RISK ADJUSTMENT.**

12 (a) IN GENERAL.—
13 (1) LOW ACTUARIAL RISK PLANS.—Using the
14 criteria and methods developed under subsection (b),
15 each State shall assess a charge on health plans and
16 health insurance issuers (with respect to health in-
17 surance coverage) described in subsection (c) if the
18 actuarial risk of the enrollees of such plans or cov-
19 erage for a year is less than the average actuarial
20 risk of all enrollees in all plans or coverage in such
21 State for such year that are not self-insured group
22 health plans (which are subject to the provisions of
23 the Employee Retirement Income Security Act of
24 1974).

1 (2) HIGH ACTUARIAL RISK PLANS.—Using the
2 criteria and methods developed under subsection (b),
3 each State shall provide a payment to health plans
4 and health insurance issuers (with respect to health
5 insurance coverage) described in subsection (c) if the
6 actuarial risk of the enrollees of such plans or cov-
7 erage for a year is greater than the average actu-
8 arial risk of all enrollees in all plans and coverage
9 in such State for such year that are not self-insured
10 group health plans (which are subject to the provi-
11 sions of the Employee Retirement Income Security
12 Act of 1974).

13 (b) CRITERIA AND METHODS.—The Secretary, in
14 consultation with States, shall establish criteria and meth-
15 ods to be used in carrying out the risk adjustment activi-
16 ties under this section. The Secretary may utilize criteria
17 and methods similar to the criteria and methods utilized
18 under part C or D of title XVIII of the Social Security
19 Act. Such criteria and methods shall be included in the
20 standards and requirements the Secretary prescribes
21 under section 1321.

22 (c) SCOPE.—A health plan or a health insurance
23 issuer is described in this subsection if such health plan
24 or health insurance issuer provides coverage in the indi-
25 vidual or small group market within the State. This sub-

1 section shall not apply to a grandfathered health plan or
2 the issuer of a grandfathered health plan with respect to
3 that plan.

4 Subtitle E—Affordable Coverage 5 Choices for All Americans

6 PART I—PREMIUM TAX CREDITS AND COST- 7 SHARING REDUCTIONS

8 Subpart A—Premium Tax Credits and Cost-sharing 9 Reductions

10 SEC. 1401. REFUNDABLE TAX CREDIT PROVIDING PREMIUM 11 ASSISTANCE FOR COVERAGE UNDER A 12 QUALIFIED HEALTH PLAN.

13 (a) IN GENERAL.—Subpart C of part IV of sub-
14 chapter A of chapter 1 of the Internal Revenue Code of
15 1986 (relating to refundable credits) is amended by insert-
16 ing after section 36A the following new section:

17 "SEC. 36B. REFUNDABLE CREDIT FOR COVERAGE UNDER A 18 QUALIFIED HEALTH PLAN.

19 "(a) IN GENERAL.—In the case of an applicable tax-
20 payer, there shall be allowed as a credit against the tax
21 imposed by this subtitle for any taxable year an amount
22 equal to the premium assistance credit amount of the tax-
23 payer for the taxable year.

24 "(b) PREMIUM ASSISTANCE CREDIT AMOUNT.—For
25 purposes of this section—

1 "(1) IN GENERAL.—The term 'premium assist-
2 ance credit amount' means, with respect to any tax-
3 able year, the sum of the premium assistance
4 amounts determined under paragraph (2) with re-
5 spect to all coverage months of the taxpayer occur-
6 ring during the taxable year.
7 "(2) PREMIUM ASSISTANCE AMOUNT.—The pre-
8 mium assistance amount determined under this sub-
9 section with respect to any coverage month is the
10 amount equal to the lesser of—
11 "(A) the monthly premiums for such
12 month for 1 or more qualified health plans of-
13 fered in the individual market within a State
14 which cover the taxpayer, the taxpayer's spouse,
15 or any dependent (as defined in section 152) of
16 the taxpayer and which were enrolled in
17 through an Exchange established by the State
18 under 1311 of the Patient Protection and Af-
19 fordable Care Act, or
20 "(B) the excess (if any) of—
21 "(i) the adjusted monthly premium
22 for such month for the applicable second
23 lowest cost silver plan with respect to the
24 taxpayer, over

"(ii) an amount equal to 1/12 of the product of the applicable percentage and the taxpayer's household income for the taxable year.

"(3) OTHER TERMS AND RULES RELATING TO PREMIUM ASSISTANCE AMOUNTS.—For purposes of paragraph (2)—

"(A) APPLICABLE PERCENTAGE.—

"(i) IN GENERAL.—Except as provided in clause (ii), the applicable percentage with respect to any taxpayer for any taxable year is equal to 2.8 percent, increased by the number of percentage points (not greater than 7) which bears the same ratio to 7 percentage points as—

"(I) the taxpayer's household income for the taxable year in excess of 100 percent of the poverty line for a family of the size involved, bears to

"(II) an amount equal to 200 percent of the poverty line for a family of the size involved.

"(ii) SPECIAL RULE FOR TAXPAYERS UNDER 133 PERCENT OF POVERTY LINE.—If a taxpayer's household income for the

1 taxable year is in excess of 100 percent,
2 but not more than 133 percent, of the pov-
3 erty line for a family of the size involved,
4 the taxpayer's applicable percentage shall
5 be 2 percent.

6 "(iii) INDEXING.—In the case of tax-
7 able years beginning in any calendar year
8 after 2014, the Secretary shall adjust the
9 initial and final applicable percentages
10 under clause (i), and the 2 percent under
11 clause (ii), for the calendar year to reflect
12 the excess of the rate of premium growth
13 between the preceding calendar year and
14 2013 over the rate of income growth for
15 such period.

16 "(B) APPLICABLE SECOND LOWEST COST
17 SILVER PLAN.—The applicable second lowest
18 cost silver plan with respect to any applicable
19 taxpayer is the second lowest cost silver plan of
20 the individual market in the rating area in
21 which the taxpayer resides which—

22 "(i) is offered through the same Ex-
23 change through which the qualified health
24 plans taken into account under paragraph
25 (2)(A) were offered, and

"(ii) provides—

"(I) self-only coverage in the case of an applicable taxpayer—

"(aa) whose tax for the taxable year is determined under section 1(c) (relating to unmarried individuals other than surviving spouses and heads of households) and who is not allowed a deduction under section 151 for the taxable year with respect to a dependent, or

"(bb) who is not described in item (aa) but who purchases only self-only coverage, and

"(II) family coverage in the case of any other applicable taxpayer.

If a taxpayer files a joint return and no credit is allowed under this section with respect to 1 of the spouses by reason of subsection (e), the taxpayer shall be treated as described in clause (ii)(I) unless a deduction is allowed under section 151 for the taxable year with respect to a dependent other than either spouse and subsection (e) does not apply to the dependent.

1 "(C) ADJUSTED MONTHLY PREMIUM.—
2 The adjusted monthly premium for an applica-
3 ble second lowest cost silver plan is the monthly
4 premium which would have been charged (for
5 the rating area with respect to which the pre-
6 miums under paragraph (2)(A) were deter-
7 mined) for the plan if each individual covered
8 under a qualified health plan taken into account
9 under paragraph (2)(A) were covered by such
10 silver plan and the premium was adjusted only
11 for the age of each such individual in the man-
12 ner allowed under section 2701 of the Public
13 Health Service Act. In the case of a State par-
14 ticipating in the wellness discount demonstra-
15 tion project under section 2705(d) of the Public
16 Health Service Act, the adjusted monthly pre-
17 mium shall be determined without regard to
18 any premium discount or rebate under such
19 project.
20 "(D) ADDITIONAL BENEFITS.—If—
21 "(i) a qualified health plan under sec-
22 tion 1302(b)(5) of the Patient Protection
23 and Affordable Care Act offers benefits in
24 addition to the essential health benefits re-
25 quired to be provided by the plan, or

"(ii) a State requires a qualified health plan under section 1311(d)(3)(B) of such Act to cover benefits in addition to the essential health benefits required to be provided by the plan,

the portion of the premium for the plan properly allocable (under rules prescribed by the Secretary of Health and Human Services) to such additional benefits shall not be taken into account in determining either the monthly premium or the adjusted monthly premium under paragraph (2).

"(E) SPECIAL RULE FOR PEDIATRIC DENTAL COVERAGE.—For purposes of determining the amount of any monthly premium, if an individual enrolls in both a qualified health plan and a plan described in section 1311(d)(2)(B)(ii)(I) of the Patient Protection and Affordable Care Act for any plan year, the portion of the premium for the plan described in such section that (under regulations prescribed by the Secretary) is properly allocable to pediatric dental benefits which are included in the essential health benefits required to be provided by a qualified health plan under sec-

1 tion 1302(b)(1)(J) of such Act shall be treated
2 as a premium payable for a qualified health
3 plan.
4 "(c) DEFINITION AND RULES RELATING TO APPLI-
5 CABLE TAXPAYERS, COVERAGE MONTHS, AND QUALIFIED
6 HEALTH PLAN.—For purposes of this section—
7 "(1) APPLICABLE TAXPAYER.—
8 "(A) IN GENERAL.—The term 'applicable
9 taxpayer' means, with respect to any taxable
10 year, a taxpayer whose household income for
11 the taxable year exceeds 100 percent but does
12 not exceed 400 percent of an amount equal to
13 the poverty line for a family of the size in-
14 volved.
15 "(B) SPECIAL RULE FOR CERTAIN INDI-
16 VIDUALS LAWFULLY PRESENT IN THE UNITED
17 STATES.—If—
18 "(i) a taxpayer has a household in-
19 come which is not greater than 100 per-
20 cent of an amount equal to the poverty line
21 for a family of the size involved, and
22 "(ii) the taxpayer is an alien lawfully
23 present in the United States, but is not eli-
24 gible for the medicaid program under title

1 XIX of the Social Security Act by reason
2 of such alien status,
3 the taxpayer shall, for purposes of the credit
4 under this section, be treated as an applicable
5 taxpayer with a household income which is
6 equal to 100 percent of the poverty line for a
7 family of the size involved.
8 "(C) MARRIED COUPLES MUST FILE JOINT
9 RETURN.—If the taxpayer is married (within
10 the meaning of section 7703) at the close of the
11 taxable year, the taxpayer shall be treated as an
12 applicable taxpayer only if the taxpayer and the
13 taxpayer's spouse file a joint return for the tax-
14 able year.
15 "(D) DENIAL OF CREDIT TO DEPEND-
16 ENTS.—No credit shall be allowed under this
17 section to any individual with respect to whom
18 a deduction under section 151 is allowable to
19 another taxpayer for a taxable year beginning
20 in the calendar year in which such individual's
21 taxable year begins.
22 "(2) COVERAGE MONTH.—For purposes of this
23 subsection—

"(A) IN GENERAL.—The term 'coverage month' means, with respect to an applicable taxpayer, any month if—

"(i) as of the first day of such month the taxpayer, the taxpayer's spouse, or any dependent of the taxpayer is covered by a qualified health plan described in subsection (b)(2)(A) that was enrolled in through an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act, and

"(ii) the premium for coverage under such plan for such month is paid by the taxpayer (or through advance payment of the credit under subsection (a) under section 1412 of the Patient Protection and Affordable Care Act).

"(B) EXCEPTION FOR MINIMUM ESSENTIAL COVERAGE.—

"(i) IN GENERAL.—The term 'coverage month' shall not include any month with respect to an individual if for such month the individual is eligible for minimum essential coverage other than eligibility for coverage described in section

1 5000A(f)(1)(C) (relating to coverage in the
2 individual market).
3 "(ii) MINIMUM ESSENTIAL COV-
4 ERAGE.—The term 'minimum essential
5 coverage' has the meaning given such term
6 by section 5000A(f).
7 "(C) SPECIAL RULE FOR EMPLOYER-SPON-
8 SORED MINIMUM ESSENTIAL COVERAGE.—For
9 purposes of subparagraph (B)—
10 "(i) COVERAGE MUST BE AFFORD-
11 ABLE.—Except as provided in clause (iii),
12 an employee shall not be treated as eligible
13 for minimum essential coverage if such
14 coverage—
15 "(I) consists of an eligible em-
16 ployer-sponsored plan (as defined in
17 section 5000A(f)(2)), and
18 "(II) the employee's required
19 contribution (within the meaning of
20 section 5000A(e)(1)(B)) with respect
21 to the plan exceeds 9.8 percent of the
22 applicable taxpayer's household in-
23 come.
24 This clause shall also apply to an indi-
25 vidual who is eligible to enroll in the plan

by reason of a relationship the individual bears to the employee.

"(ii) COVERAGE MUST PROVIDE MINIMUM VALUE.—Except as provided in clause (iii), an employee shall not be treated as eligible for minimum essential coverage if such coverage consists of an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) and the plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs.

"(iii) EMPLOYEE OR FAMILY MUST NOT BE COVERED UNDER EMPLOYER PLAN.—Clauses (i) and (ii) shall not apply if the employee (or any individual described in the last sentence of clause (i)) is covered under the eligible employer-sponsored plan or the grandfathered health plan.

"(iv) INDEXING.—In the case of plan years beginning in any calendar year after 2014, the Secretary shall adjust the 9.8 percent under clause (i)(II) in the same

manner as the percentages are adjusted under subsection (b)(3)(A)(ii).

"(3) DEFINITIONS AND OTHER RULES.—

"(A) QUALIFIED HEALTH PLAN.—The term 'qualified health plan' has the meaning given such term by section 1301(a) of the Patient Protection and Affordable Care Act, except that such term shall not include a qualified health plan which is a catastrophic plan described in section 1302(e) of such Act.

"(B) GRANDFATHERED HEALTH PLAN.—The term 'grandfathered health plan' has the meaning given such term by section 1251 of the Patient Protection and Affordable Care Act.

"(d) TERMS RELATING TO INCOME AND FAMILIES.—For purposes of this section—

"(1) FAMILY SIZE.—The family size involved with respect to any taxpayer shall be equal to the number of individuals for whom the taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year.

"(2) HOUSEHOLD INCOME.—

"(A) HOUSEHOLD INCOME.—The term 'household income' means, with respect to any taxpayer, an amount equal to the sum of—

"(i) the modified gross income of the taxpayer, plus

"(ii) the aggregate modified gross incomes of all other individuals who—

"(I) were taken into account in determining the taxpayer's family size under paragraph (1), and

"(II) were required to file a return of tax imposed by section 1 for the taxable year.

"(B) MODIFIED GROSS INCOME.—The term 'modified gross income' means gross income—

"(i) decreased by the amount of any deduction allowable under paragraph (1), (3), (4), or (10) of section 62(a),

"(ii) increased by the amount of interest received or accrued during the taxable year which is exempt from tax imposed by this chapter, and

"(iii) determined without regard to sections 911, 931, and 933.

"(3) POVERTY LINE.—

"(A) IN GENERAL.—The term 'poverty line' has the meaning given that term in section 2110(c)(5) of the Social Security Act (42 U.S.C. 1397jj(c)(5)).

"(B) POVERTY LINE USED.—In the case of any qualified health plan offered through an Exchange for coverage during a taxable year beginning in a calendar year, the poverty line used shall be the most recently published poverty line as of the 1st day of the regular enrollment period for coverage during such calendar year.

"(e) RULES FOR INDIVIDUALS NOT LAWFULLY PRESENT.—

"(1) IN GENERAL.—If 1 or more individuals for whom a taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year (including the taxpayer or his spouse) are individuals who are not lawfully present—

"(A) the aggregate amount of premiums otherwise taken into account under clauses (i) and (ii) of subsection (b)(2)(A) shall be reduced

by the portion (if any) of such premiums which is attributable to such individuals, and

"(B) for purposes of applying this section, the determination as to what percentage a taxpayer's household income bears to the poverty level for a family of the size involved shall be made under one of the following methods:

"(i) A method under which—

"(I) the taxpayer's family size is determined by not taking such individuals into account, and

"(II) the taxpayer's household income is equal to the product of the taxpayer's household income (determined without regard to this subsection) and a fraction—

"(aa) the numerator of which is the poverty line for the taxpayer's family size determined after application of subclause (I), and

"(bb) the denominator of which is the poverty line for the taxpayer's family size determined without regard to subclause (I).

1 "(ii) A comparable method reaching
2 the same result as the method under
3 clause (i).

4 "(2) LAWFULLY PRESENT.—For purposes of
5 this section, an individual shall be treated as law-
6 fully present only if the individual is, and is reason-
7 ably expected to be for the entire period of enroll-
8 ment for which the credit under this section is being
9 claimed, a citizen or national of the United States
10 or an alien lawfully present in the United States.

11 "(3) SECRETARIAL AUTHORITY.—The Secretary
12 of Health and Human Services, in consultation with
13 the Secretary, shall prescribe rules setting forth the
14 methods by which calculations of family size and
15 household income are made for purposes of this sub-
16 section. Such rules shall be designed to ensure that
17 the least burden is placed on individuals enrolling in
18 qualified health plans through an Exchange and tax-
19 payers eligible for the credit allowable under this
20 section.

21 "(f) RECONCILIATION OF CREDIT AND ADVANCE
22 CREDIT.—

23 "(1) IN GENERAL.—The amount of the credit
24 allowed under this section for any taxable year shall
25 be reduced (but not below zero) by the amount of

1 any advance payment of such credit under section
2 1412 of the Patient Protection and Affordable Care
3 Act.

4 "(2) EXCESS ADVANCE PAYMENTS.—

5 "(A) IN GENERAL.—If the advance pay-
6 ments to a taxpayer under section 1412 of the
7 Patient Protection and Affordable Care Act for
8 a taxable year exceed the credit allowed by this
9 section (determined without regard to para-
10 graph (1)), the tax imposed by this chapter for
11 the taxable year shall be increased by the
12 amount of such excess.

13 "(B) LIMITATION ON INCREASE WHERE
14 INCOME LESS THAN 400 PERCENT OF POVERTY
15 LINE.—

16 "(i) IN GENERAL.—In the case of an
17 applicable taxpayer whose household in-
18 come is less than 400 percent of the pov-
19 erty line for the size of the family involved
20 for the taxable year, the amount of the in-
21 crease under subparagraph (A) shall in no
22 event exceed $400 ($250 in the case of a
23 taxpayer whose tax is determined under
24 section 1(c) for the taxable year).

1 "(ii) INDEXING OF AMOUNT.—In the
2 case of any calendar year beginning after
3 2014, each of the dollar amounts under
4 clause (i) shall be increased by an amount
5 equal to—
6 "(I) such dollar amount, multi-
7 plied by
8 "(II) the cost-of-living adjust-
9 ment determined under section 1(f)(3)
10 for the calendar year, determined by
11 substituting 'calendar year 2013' for
12 'calendar year 1992' in subparagraph
13 (B) thereof.
14 If the amount of any increase under clause
15 (i) is not a multiple of $50, such increase
16 shall be rounded to the next lowest mul-
17 tiple of $50.
18 "(g) REGULATIONS.—The Secretary shall prescribe
19 such regulations as may be necessary to carry out the pro-
20 visions of this section, including regulations which provide
21 for—
22 "(1) the coordination of the credit allowed
23 under this section with the program for advance
24 payment of the credit under section 1412 of the Pa-
25 tient Protection and Affordable Care Act, and

"(2) the application of subsection (f) where the filing status of the taxpayer for a taxable year is different from such status used for determining the advance payment of the credit.".

(b) DISALLOWANCE OF DEDUCTION.—Section 280C of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

"(g) CREDIT FOR HEALTH INSURANCE PREMIUMS.—No deduction shall be allowed for the portion of the premiums paid by the taxpayer for coverage of 1 or more individuals under a qualified health plan which is equal to the amount of the credit determined for the taxable year under section 36B(a) with respect to such premiums.".

(c) STUDY ON AFFORDABLE COVERAGE.—

(1) STUDY AND REPORT.—

(A) IN GENERAL.—Not later than 5 years after the date of the enactment of this Act, the Comptroller General shall conduct a study on the affordability of health insurance coverage, including—

(i) the impact of the tax credit for qualified health insurance coverage of individuals under section 36B of the Internal Revenue Code of 1986 and the tax credit

for employee health insurance expenses of small employers under section 45R of such Code on maintaining and expanding the health insurance coverage of individuals;

(ii) the availability of affordable health benefits plans, including a study of whether the percentage of household income used for purposes of section 36B(c)(2)(C) of the Internal Revenue Code of 1986 (as added by this section) is the appropriate level for determining whether employer-provided coverage is affordable for an employee and whether such level may be lowered without significantly increasing the costs to the Federal Government and reducing employer-provided coverage; and

(iii) the ability of individuals to maintain essential health benefits coverage (as defined in section 5000A(f) of the Internal Revenue Code of 1986).

(B) REPORT.—The Comptroller General shall submit to the appropriate committees of Congress a report on the study conducted under subparagraph (A), together with legislative rec-

ommendations relating to the matters studied under such subparagraph.

(2) APPROPRIATE COMMITTEES OF CONGRESS.—In this subsection, the term ''appropriate committees of Congress'' means the Committee on Ways and Means, the Committee on Education and Labor, and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance and the Committee on Health, Education, Labor and Pensions of the Senate.

(d) CONFORMING AMENDMENTS.—

(1) Paragraph (2) of section 1324(b) of title 31, United States Code, is amended by inserting ''36B,'' after ''36A,''.

(2) The table of sections for subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after the item relating to section 36A the following new item:

''Sec. 36B. Refundable credit for coverage under a qualified health plan.''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years ending after December 31, 2013.

SEC. 1402. REDUCED COST-SHARING FOR INDIVIDUALS ENROLLING IN QUALIFIED HEALTH PLANS.

(a) IN GENERAL.—In the case of an eligible insured enrolled in a qualified health plan—

(1) the Secretary shall notify the issuer of the plan of such eligibility; and

(2) the issuer shall reduce the cost-sharing under the plan at the level and in the manner specified in subsection (c).

(b) ELIGIBLE INSURED.—In this section, the term ''eligible insured'' means an individual—

(1) who enrolls in a qualified health plan in the silver level of coverage in the individual market offered through an Exchange; and

(2) whose household income exceeds 100 percent but does not exceed 400 percent of the poverty line for a family of the size involved.

In the case of an individual described in section 36B(c)(1)(B) of the Internal Revenue Code of 1986, the individual shall be treated as having household income equal to 100 percent for purposes of applying this section.

(c) DETERMINATION OF REDUCTION IN COST-SHARING.—

(1) REDUCTION IN OUT-OF-POCKET LIMIT.—

(A) IN GENERAL.—The reduction in cost-sharing under this subsection shall first be achieved by reducing the applicable out-of pocket limit under section 1302(c)(1) in the case of—

(i) an eligible insured whose household income is more than 100 percent but not more than 200 percent of the poverty line for a family of the size involved, by two-thirds;

(ii) an eligible insured whose household income is more than 200 percent but not more than 300 percent of the poverty line for a family of the size involved, by one-half; and

(iii) an eligible insured whose household income is more than 300 percent but not more than 400 percent of the poverty line for a family of the size involved, by one-third.

(B) COORDINATION WITH ACTUARIAL VALUE LIMITS.—

(i) IN GENERAL.—The Secretary shall ensure the reduction under this paragraph shall not result in an increase in the plan's share of the total allowed costs of benefits provided under the plan above—

(I) 90 percent in the case of an eligible insured described in paragraph (2)(A);

(II) 80 percent in the case of an eligible insured described in paragraph (2)(B); and

(III) 70 percent in the case of an eligible insured described in clause (ii) or (iii) of subparagraph (A).

(ii) ADJUSTMENT.—The Secretary shall adjust the out-of pocket limits under paragraph (1) if necessary to ensure that such limits do not cause the respective actuarial values to exceed the levels specified in clause (i).

(2) ADDITIONAL REDUCTION FOR LOWER INCOME INSUREDS.—The Secretary shall establish procedures under which the issuer of a qualified health plan to which this section applies shall further reduce cost-sharing under the plan in a manner sufficient to—

(A) in the case of an eligible insured whose household income is not less than 100 percent but not more than 150 percent of the poverty line for a family of the size involved, increase the plan's share of the total allowed costs of benefits provided under the plan to 90 percent of such costs; and

(B) in the case of an eligible insured whose household income is more than 150 percent but not more than 200 percent of the poverty line for a family of the size involved, increase the plan's share of the total allowed costs of benefits provided under the plan to 80 percent of such costs.

(3) METHODS FOR REDUCING COST-SHARING.—

(A) IN GENERAL.—An issuer of a qualified health plan making reductions under this subsection shall notify the Secretary of such reductions and the Secretary shall make periodic and timely payments to the issuer equal to the value of the reductions.

(B) CAPITATED PAYMENTS.—The Secretary may establish a capitated payment system to carry out the payment of cost-sharing reductions under this section. Any such system shall take into account the value of the reductions and make appropriate risk adjustments to such payments.

(4) ADDITIONAL BENEFITS.—If a qualified health plan under section 1302(b)(5) offers benefits in addition to the essential health benefits required to be provided by the plan, or a State requires a

1 qualified health plan under section 1311(d)(3)(B) to
2 cover benefits in addition to the essential health ben-
3 efits required to be provided by the plan, the reduc-
4 tions in cost-sharing under this section shall not
5 apply to such additional benefits.

6 (5) SPECIAL RULE FOR PEDIATRIC DENTAL
7 PLANS.—If an individual enrolls in both a qualified
8 health plan and a plan described in section
9 1311(d)(2)(B)(ii)(I) for any plan year, subsection
10 (a) shall not apply to that portion of any reduction
11 in cost-sharing under subsection (c) that (under reg-
12 ulations prescribed by the Secretary) is properly al-
13 locable to pediatric dental benefits which are in-
14 cluded in the essential health benefits required to be
15 provided by a qualified health plan under section
16 1302(b)(1)(J).

17 (d) SPECIAL RULES FOR INDIANS.—

18 (1) INDIANS UNDER 300 PERCENT OF POV-
19 ERTY.—If an individual enrolled in any qualified
20 health plan in the individual market through an Ex-
21 change is an Indian (as defined in section 4(d) of
22 the Indian Self-Determination and Education Assist-
23 ance Act (25 U.S.C. 450b(d))) whose household in-
24 come is not more than 300 percent of the poverty

line for a family of the size involved, then, for purposes of this section—

(A) such individual shall be treated as an eligible insured; and

(B) the issuer of the plan shall eliminate any cost-sharing under the plan.

(2) ITEMS OR SERVICES FURNISHED THROUGH INDIAN HEALTH PROVIDERS.—If an Indian (as so defined) enrolled in a qualified health plan is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services—

(A) no cost-sharing under the plan shall be imposed under the plan for such item or service; and

(B) the issuer of the plan shall not reduce the payment to any such entity for such item or service by the amount of any cost-sharing that would be due from the Indian but for subparagraph (A).

(3) PAYMENT.—The Secretary shall pay to the issuer of a qualified health plan the amount necessary to reflect the increase in actuarial value of the plan required by reason of this subsection.

1 (e) RULES FOR INDIVIDUALS NOT LAWFULLY
2 PRESENT.—
3 (1) IN GENERAL.—If an individual who is an el-
4 igible insured is not lawfully present—
5 (A) no cost-sharing reduction under this
6 section shall apply with respect to the indi-
7 vidual; and
8 (B) for purposes of applying this section,
9 the determination as to what percentage a tax-
10 payer's household income bears to the poverty
11 level for a family of the size involved shall be
12 made under one of the following methods:
13 (i) A method under which—
14 (I) the taxpayer's family size is
15 determined by not taking such indi-
16 viduals into account, and
17 (II) the taxpayer's household in-
18 come is equal to the product of the
19 taxpayer's household income (deter-
20 mined without regard to this sub-
21 section) and a fraction—
22 (aa) the numerator of which
23 is the poverty line for the tax-
24 payer's family size determined

after application of subclause (I), and

(bb) the denominator of which is the poverty line for the taxpayer's family size determined without regard to subclause (I).

(ii) A comparable method reaching the same result as the method under clause (i).

(2) LAWFULLY PRESENT.—For purposes of this section, an individual shall be treated as lawfully present only if the individual is, and is reasonably expected to be for the entire period of enrollment for which the cost-sharing reduction under this section is being claimed, a citizen or national of the United States or an alien lawfully present in the United States.

(3) SECRETARIAL AUTHORITY.—The Secretary, in consultation with the Secretary of the Treasury, shall prescribe rules setting forth the methods by which calculations of family size and household income are made for purposes of this subsection. Such rules shall be designed to ensure that the least burden is placed on individuals enrolling in qualified health plans through an Exchange and taxpayers eligible for the credit allowable under this section.

(f) DEFINITIONS AND SPECIAL RULES.—In this section:

(1) IN GENERAL.—Any term used in this section which is also used in section 36B of the Internal Revenue Code of 1986 shall have the meaning given such term by such section.

(2) LIMITATIONS ON REDUCTION.—No cost-sharing reduction shall be allowed under this section with respect to coverage for any month unless the month is a coverage month with respect to which a credit is allowed to the insured (or an applicable taxpayer on behalf of the insured) under section 36B of such Code.

(3) DATA USED FOR ELIGIBILITY.—Any determination under this section shall be made on the basis of the taxable year for which the advance determination is made under section 1412 and not the taxable year for which the credit under section 36B of such Code is allowed.

1 **Subpart B—Eligibility Determinations**

2 **SEC. 1411. PROCEDURES FOR DETERMINING ELIGIBILITY**
3 **FOR EXCHANGE PARTICIPATION, PREMIUM**
4 **TAX CREDITS AND REDUCED COST-SHARING ,**
5 **AND INDIVIDUAL RESPONSIBILITY EXEMP-**
6 **TIONS.**

7 (a) ESTABLISHMENT OF PROGRAM.—The Secretary
8 shall establish a program meeting the requirements of this
9 section for determining—

10 (1) whether an individual who is to be covered
11 in the individual market by a qualified health plan
12 offered through an Exchange, or who is claiming a
13 premium tax credit or reduced cost-sharing, meets
14 the requirements of sections 1312(f)(3), 1402(e),
15 and 1412(d) of this title and section 36B(e) of the
16 Internal Revenue Code of 1986 that the individual
17 be a citizen or national of the United States or an
18 alien lawfully present in the United States;

19 (2) in the case of an individual claiming a pre-
20 mium tax credit or reduced cost-sharing under sec-
21 tion 36B of such Code or section 1402—

22 (A) whether the individual meets the in-
23 come and coverage requirements of such sec-
24 tions; and

25 (B) the amount of the tax credit or re-
26 duced cost-sharing;

(3) whether an individual's coverage under an employer-sponsored health benefits plan is treated as unaffordable under sections 36B(c)(2)(C) and 5000A(e)(2); and

(4) whether to grant a certification under section 1311(d)(4)(H) attesting that, for purposes of the individual responsibility requirement under section 5000A of the Internal Revenue Code of 1986, an individual is entitled to an exemption from either the individual responsibility requirement or the penalty imposed by such section.

(b) INFORMATION REQUIRED TO BE PROVIDED BY APPLICANTS.—

(1) IN GENERAL.—An applicant for enrollment in a qualified health plan offered through an Exchange in the individual market shall provide—

(A) the name, address, and date of birth of each individual who is to be covered by the plan (in this subsection referred to as an ''enrollee''); and

(B) the information required by any of the following paragraphs that is applicable to an enrollee.

(2) CITIZENSHIP OR IMMIGRATION STATUS.—The following information shall be provided with respect to every enrollee:

(A) In the case of an enrollee whose eligibility is based on an attestation of citizenship of the enrollee, the enrollee's social security number.

(B) In the case of an individual whose eligibility is based on an attestation of the enrollee's immigration status, the enrollee's social security number (if applicable) and such identifying information with respect to the enrollee's immigration status as the Secretary, after consultation with the Secretary of Homeland Security, determines appropriate.

(3) ELIGIBILITY AND AMOUNT OF TAX CREDIT OR REDUCED COST-SHARING.—In the case of an enrollee with respect to whom a premium tax credit or reduced cost-sharing under section 36B of such Code or section 1402 is being claimed, the following information:

(A) INFORMATION REGARDING INCOME AND FAMILY SIZE.—The information described in section 6103(l)(21) for the taxable year ending with or within the second calendar year pre-

ceding the calendar year in which the plan year begins.

(B) CHANGES IN CIRCUMSTANCES.—The information described in section 1412(b)(2), including information with respect to individuals who were not required to file an income tax return for the taxable year described in subparagraph (A) or individuals who experienced changes in marital status or family size or significant reductions in income.

(4) EMPLOYER-SPONSORED COVERAGE.—In the case of an enrollee with respect to whom eligibility for a premium tax credit under section 36B of such Code or cost-sharing reduction under section 1402 is being established on the basis that the enrollee's (or related individual's) employer is not treated under section 36B(c)(2)(C) of such Code as providing minimum essential coverage or affordable minimum essential coverage, the following information:

(A) The name, address, and employer identification number (if available) of the employer.

(B) Whether the enrollee or individual is a full-time employee and whether the employer provides such minimum essential coverage.

(C) If the employer provides such minimum essential coverage, the lowest cost option for the enrollee's or individual's enrollment status and the enrollee's or individual's required contribution (within the meaning of section 5000A(e)(1)(B) of such Code) under the employer-sponsored plan.

(D) If an enrollee claims an employer's minimum essential coverage is unaffordable, the information described in paragraph (3).

If an enrollee changes employment or obtains additional employment while enrolled in a qualified health plan for which such credit or reduction is allowed, the enrollee shall notify the Exchange of such change or additional employment and provide the information described in this paragraph with respect to the new employer.

(5) EXEMPTIONS FROM INDIVIDUAL RESPONSIBILITY REQUIREMENTS.—In the case of an individual who is seeking an exemption certificate under section 1311(d)(4)(H) from any requirement or penalty imposed by section 5000A, the following information:

(A) In the case of an individual seeking exemption based on the individual's status as a

1 member of an exempt religious sect or division,
2 as a member of a health care sharing ministry,
3 as an Indian, or as an individual eligible for a
4 hardship exemption, such information as the
5 Secretary shall prescribe.
6 (B) In the case of an individual seeking ex-
7 emption based on the lack of affordable cov-
8 erage or the individual's status as a taxpayer
9 with household income less than 100 percent of
10 the poverty line, the information described in
11 paragraphs (3) and (4), as applicable.
12 (c) VERIFICATION OF INFORMATION CONTAINED IN
13 RECORDS OF SPECIFIC FEDERAL OFFICIALS.—
14 (1) INFORMATION TRANSFERRED TO SEC-
15 RETARY.—An Exchange shall submit the informa-
16 tion provided by an applicant under subsection (b)
17 to the Secretary for verification in accordance with
18 the requirements of this subsection and subsection
19 (d).
20 (2) CITIZENSHIP OR IMMIGRATION STATUS.—
21 (A) COMMISSIONER OF SOCIAL SECU-
22 RITY.—The Secretary shall submit to the Com-
23 missioner of Social Security the following infor-
24 mation for a determination as to whether the

information provided is consistent with the information in the records of the Commissioner:

(i) The name, date of birth, and social security number of each individual for whom such information was provided under subsection (b)(2).

(ii) The attestation of an individual that the individual is a citizen.

(B) SECRETARY OF HOMELAND SECURITY.—

(i) IN GENERAL.—In the case of an individual—

(I) who attests that the individual is an alien lawfully present in the United States; or

(II) who attests that the individual is a citizen but with respect to whom the Commissioner of Social Security has notified the Secretary under subsection (e)(3) that the attestation is inconsistent with information in the records maintained by the Commissioner;

the Secretary shall submit to the Secretary of Homeland Security the information de-

scribed in clause (ii) for a determination as to whether the information provided is consistent with the information in the records of the Secretary of Homeland Security.

(ii) INFORMATION.—The information described in clause (ii) is the following:

(I) The name, date of birth, and any identifying information with respect to the individual's immigration status provided under subsection (b)(2).

(II) The attestation that the individual is an alien lawfully present in the United States or in the case of an individual described in clause (i)(II), the attestation that the individual is a citizen.

(3) ELIGIBILITY FOR TAX CREDIT AND COST-SHARING REDUCTION.—The Secretary shall submit the information described in subsection (b)(3)(A) provided under paragraph (3), (4), or (5) of subsection (b) to the Secretary of the Treasury for verification of household income and family size for purposes of eligibility.

(4) METHODS.—

(A) IN GENERAL.—The Secretary, in consultation with the Secretary of the Treasury, the Secretary of Homeland Security, and the Commissioner of Social Security, shall provide that verifications and determinations under this subsection shall be done—

(i) through use of an on-line system or otherwise for the electronic submission of, and response to, the information submitted under this subsection with respect to an applicant; or

(ii) by determining the consistency of the information submitted with the information maintained in the records of the Secretary of the Treasury, the Secretary of Homeland Security, or the Commissioner of Social Security through such other method as is approved by the Secretary.

(B) FLEXIBILITY.—The Secretary may modify the methods used under the program established by this section for the Exchange and verification of information if the Secretary determines such modifications would reduce the administrative costs and burdens on the applicant, including allowing an applicant to request

the Secretary of the Treasury to provide the information described in paragraph (3) directly to the Exchange or to the Secretary. The Secretary shall not make any such modification unless the Secretary determines that any applicable requirements under this section and section 6103 of the Internal Revenue Code of 1986 with respect to the confidentiality, disclosure, maintenance, or use of information will be met.

(d) VERIFICATION BY SECRETARY.—In the case of information provided under subsection (b) that is not required under subsection (c) to be submitted to another person for verification, the Secretary shall verify the accuracy of such information in such manner as the Secretary determines appropriate, including delegating responsibility for verification to the Exchange.

(e) ACTIONS RELATING TO VERIFICATION.—

(1) IN GENERAL.—Each person to whom the Secretary provided information under subsection (c) shall report to the Secretary under the method established under subsection (c)(4) the results of its verification and the Secretary shall notify the Exchange of such results. Each person to whom the Secretary provided information under subsection (d)

shall report to the Secretary in such manner as the Secretary determines appropriate.

(2) VERIFICATION.—

(A) ELIGIBILITY FOR ENROLLMENT AND PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS.—If information provided by an applicant under paragraphs (1), (2), (3), and (4) of subsection (b) is verified under subsections (c) and (d)—

(i) the individual's eligibility to enroll through the Exchange and to apply for premium tax credits and cost-sharing reductions shall be satisfied; and

(ii) the Secretary shall, if applicable, notify the Secretary of the Treasury under section 1412(c) of the amount of any advance payment to be made.

(B) EXEMPTION FROM INDIVIDUAL RESPONSIBILITY.—If information provided by an applicant under subsection (b)(5) is verified under subsections (c) and (d), the Secretary shall issue the certification of exemption described in section 1311(d)(4)(H).

(3) INCONSISTENCIES INVOLVING ATTESTATION OF CITIZENSHIP OR LAWFUL PRESENCE.—If the in-

formation provided by any applicant under subsection (b)(2) is inconsistent with information in the records maintained by the Commissioner of Social Security or Secretary of Homeland Security, whichever is applicable, the applicant's eligibility will be determined in the same manner as an individual's eligibility under the medicaid program is determined under section 1902(ee) of the Social Security Act (as in effect on January 1, 2010).

(4) INCONSISTENCIES INVOLVING OTHER INFORMATION.—

(A) IN GENERAL.—If the information provided by an applicant under subsection (b) (other than subsection (b)(2)) is inconsistent with information in the records maintained by persons under subsection (c) or is not verified under subsection (d), the Secretary shall notify the Exchange and the Exchange shall take the following actions:

(i) REASONABLE EFFORT.—The Exchange shall make a reasonable effort to identify and address the causes of such inconsistency, including through typographical or other clerical errors, by contacting the applicant to confirm the accu-

1 racy of the information, and by taking
2 such additional actions as the Secretary,
3 through regulation or other guidance, may
4 identify.
5 (ii) NOTICE AND OPPORTUNITY TO
6 CORRECT.—In the case the inconsistency
7 or inability to verify is not resolved under
8 subparagraph (A), the Exchange shall—
9 (I) notify the applicant of such
10 fact;
11 (II) provide the applicant an op-
12 portunity to either present satisfac-
13 tory documentary evidence or resolve
14 the inconsistency with the person
15 verifying the information under sub-
16 section (c) or (d) during the 90-day
17 period beginning the date on which
18 the notice required under subclause
19 (I) is sent to the applicant.
20 The Secretary may extend the 90-day pe-
21 riod under subclause (II) for enrollments
22 occurring during 2014.
23 (B) SPECIFIC ACTIONS NOT INVOLVING
24 CITIZENSHIP OR LAWFUL PRESENCE.—

1 (i) IN GENERAL.—Except as provided
2 in paragraph (3), the Exchange shall, dur-
3 ing any period before the close of the pe-
4 riod under subparagraph (A)(ii)(II), make
5 any determination under paragraphs (2),
6 (3), and (4) of subsection (a) on the basis
7 of the information contained on the appli-
8 cation.
9 (ii) ELIGIBILITY OR AMOUNT OF
10 CREDIT OR REDUCTION.—If an inconsist-
11 ency involving the eligibility for, or amount
12 of, any premium tax credit or cost-sharing
13 reduction is unresolved under this sub-
14 section as of the close of the period under
15 subparagraph (A)(ii)(II), the Exchange
16 shall notify the applicant of the amount (if
17 any) of the credit or reduction that is de-
18 termined on the basis of the records main-
19 tained by persons under subsection (c).
20 (iii) EMPLOYER AFFORDABILITY.—If
21 the Secretary notifies an Exchange that an
22 enrollee is eligible for a premium tax credit
23 under section 36B of such Code or cost-
24 sharing reduction under section 1402 be-
25 cause the enrollee's (or related individ-

1 ual's) employer does not provide minimum
2 essential coverage through an employer-
3 sponsored plan or that the employer does
4 provide that coverage but it is not afford-
5 able coverage, the Exchange shall notify
6 the employer of such fact and that the em-
7 ployer may be liable for the payment as-
8 sessed under section 4980H of such Code.
9 (iv) EXEMPTION.—In any case where
10 the inconsistency involving, or inability to
11 verify, information provided under sub-
12 section (b)(5) is not resolved as of the
13 close of the period under subparagraph
14 (A)(ii)(II), the Exchange shall notify an
15 applicant that no certification of exemption
16 from any requirement or payment under
17 section 5000A of such Code will be issued.
18 (C) APPEALS PROCESS.—The Exchange
19 shall also notify each person receiving notice
20 under this paragraph of the appeals processes
21 established under subsection (f).
22 (f) APPEALS AND REDETERMINATIONS.—
23 (1) IN GENERAL.—The Secretary, in consulta-
24 tion with the Secretary of the Treasury, the Sec-
25 retary of Homeland Security, and the Commissioner

of Social Security, shall establish procedures by which the Secretary or one of such other Federal officers—

(A) hears and makes decisions with respect to appeals of any determination under subsection (e); and

(B) redetermines eligibility on a periodic basis in appropriate circumstances.

(2) EMPLOYER LIABILITY.—

(A) IN GENERAL.—The Secretary shall establish a separate appeals process for employers who are notified under subsection (e)(4)(C) that the employer may be liable for a tax imposed by section 4980H of the Internal Revenue Code of 1986 with respect to an employee because of a determination that the employer does not provide minimum essential coverage through an employer-sponsored plan or that the employer does provide that coverage but it is not affordable coverage with respect to an employee. Such process shall provide an employer the opportunity to—

(i) present information to the Exchange for review of the determination either by the Exchange or the person mak-

ing the determination, including evidence of the employer-sponsored plan and employer contributions to the plan; and

(ii) have access to the data used to make the determination to the extent allowable by law.

Such process shall be in addition to any rights of appeal the employer may have under subtitle F of such Code.

(B) CONFIDENTIALITY.—Notwithstanding any provision of this title (or the amendments made by this title) or section 6103 of the Internal Revenue Code of 1986, an employer shall not be entitled to any taxpayer return information with respect to an employee for purposes of determining whether the employer is subject to the penalty under section 4980H of such Code with respect to the employee, except that—

(i) the employer may be notified as to the name of an employee and whether or not the employee's income is above or below the threshold by which the affordability of an employer's health insurance coverage is measured; and

1 (ii) this subparagraph shall not apply
2 to an employee who provides a waiver (at
3 such time and in such manner as the Sec-
4 retary may prescribe) authorizing an em-
5 ployer to have access to the employee's tax-
6 payer return information.
7 (g) CONFIDENTIALITY OF APPLICANT INFORMA-
8 TION.—
9 (1) IN GENERAL.—An applicant for insurance
10 coverage or for a premium tax credit or cost-sharing
11 reduction shall be required to provide only the infor-
12 mation strictly necessary to authenticate identity,
13 determine eligibility, and determine the amount of
14 the credit or reduction.
15 (2) RECEIPT OF INFORMATION.—Any person
16 who receives information provided by an applicant
17 under subsection (b) (whether directly or by another
18 person at the request of the applicant), or receives
19 information from a Federal agency under subsection
20 (c), (d), or (e), shall—
21 (A) use the information only for the pur-
22 poses of, and to the extent necessary in, ensur-
23 ing the efficient operation of the Exchange, in-
24 cluding verifying the eligibility of an individual
25 to enroll through an Exchange or to claim a

premium tax credit or cost-sharing reduction or the amount of the credit or reduction; and

(B) not disclose the information to any other person except as provided in this section.

(h) PENALTIES.—

(1) FALSE OR FRAUDULENT INFORMATION.—

(A) CIVIL PENALTY.—

(i) IN GENERAL.—If—

(I) any person fails to provides correct information under subsection (b); and

(II) such failure is attributable to negligence or disregard of any rules or regulations of the Secretary,

such person shall be subject, in addition to any other penalties that may be prescribed by law, to a civil penalty of not more than $25,000 with respect to any failures involving an application for a plan year. For purposes of this subparagraph, the terms ''negligence'' and ''disregard'' shall have the same meanings as when used in section 6662 of the Internal Revenue Code of 1986.

(ii) REASONABLE CAUSE EXCEPTION.—No penalty shall be imposed under clause (i) if the Secretary determines that there was a reasonable cause for the failure and that the person acted in good faith.

(B) KNOWING AND WILLFUL VIOLATIONS.—Any person who knowingly and willfully provides false or fraudulent information under subsection (b) shall be subject, in addition to any other penalties that may be prescribed by law, to a civil penalty of not more than $250,000.

(2) IMPROPER USE OR DISCLOSURE OF INFORMATION.—Any person who knowingly and willfully uses or discloses information in violation of subsection (g) shall be subject, in addition to any other penalties that may be prescribed by law, to a civil penalty of not more than $25,000.

(3) LIMITATIONS ON LIENS AND LEVIES.—The Secretary (or, if applicable, the Attorney General of the United States) shall not—

(A) file notice of lien with respect to any property of a person by reason of any failure to pay the penalty imposed by this subsection; or

1 (B) levy on any such property with respect
2 to such failure.
3 (i) STUDY OF ADMINISTRATION OF EMPLOYER RE-
4 SPONSIBILITY.—
5 (1) IN GENERAL.—The Secretary of Health and
6 Human Services shall, in consultation with the Sec-
7 retary of the Treasury, conduct a study of the proce-
8 dures that are necessary to ensure that in the ad-
9 ministration of this title and section 4980H of the
10 Internal Revenue Code of 1986 (as added by section
11 1513) that the following rights are protected:
12 (A) The rights of employees to preserve
13 their right to confidentiality of their taxpayer
14 return information and their right to enroll in
15 a qualified health plan through an Exchange if
16 an employer does not provide affordable cov-
17 erage.
18 (B) The rights of employers to adequate
19 due process and access to information necessary
20 to accurately determine any payment assessed
21 on employers.
22 (2) REPORT.—Not later than January 1, 2013,
23 the Secretary of Health and Human Services shall
24 report the results of the study conducted under
25 paragraph (1), including any recommendations for

legislative changes, to the Committees on Finance and Health, Education, Labor and Pensions of the Senate and the Committees of Education and Labor and Ways and Means of the House of Representatives.

SEC. 1412. ADVANCE DETERMINATION AND PAYMENT OF PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS.

(a) IN GENERAL.—The Secretary, in consultation with the Secretary of the Treasury, shall establish a program under which—

(1) upon request of an Exchange, advance determinations are made under section 1411 with respect to the income eligibility of individuals enrolling in a qualified health plan in the individual market through the Exchange for the premium tax credit allowable under section 36B of the Internal Revenue Code of 1986 and the cost-sharing reductions under section 1402;

(2) the Secretary notifies—

(A) the Exchange and the Secretary of the Treasury of the advance determinations; and

(B) the Secretary of the Treasury of the name and employer identification number of each employer with respect to whom 1 or more

employee of the employer were determined to be eligible for the premium tax credit under section 36B of the Internal Revenue Code of 1986 and the cost-sharing reductions under section 1402 because—

(i) the employer did not provide minimum essential coverage; or

(ii) the employer provided such minimum essential coverage but it was determined under section 36B(c)(2)(C) of such Code to either be unaffordable to the employee or not provide the required minimum actuarial value; and

(3) the Secretary of the Treasury makes advance payments of such credit or reductions to the issuers of the qualified health plans in order to reduce the premiums payable by individuals eligible for such credit.

(b) ADVANCE DETERMINATIONS.—

(1) IN GENERAL.—The Secretary shall provide under the program established under subsection (a) that advance determination of eligibility with respect to any individual shall be made—

(A) during the annual open enrollment period applicable to the individual (or such other

enrollment period as may be specified by the Secretary); and

(B) on the basis of the individual's household income for the most recent taxable year for which the Secretary, after consultation with the Secretary of the Treasury, determines information is available.

(2) CHANGES IN CIRCUMSTANCES.—The Secretary shall provide procedures for making advance determinations on the basis of information other than that described in paragraph (1)(B) in cases where information included with an application form demonstrates substantial changes in income, changes in family size or other household circumstances, change in filing status, the filing of an application for unemployment benefits, or other significant changes affecting eligibility, including—

(A) allowing an individual claiming a decrease of 20 percent or more in income, or filing an application for unemployment benefits, to have eligibility for the credit determined on the basis of household income for a later period or on the basis of the individual's estimate of such income for the taxable year; and

(B) the determination of household income in cases where the taxpayer was not required to file a return of tax imposed by this chapter for the second preceding taxable year.

(c) PAYMENT OF PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS.—

(1) IN GENERAL.—The Secretary shall notify the Secretary of the Treasury and the Exchange through which the individual is enrolling of the advance determination under section 1411.

(2) PREMIUM TAX CREDIT.—

(A) IN GENERAL.—The Secretary of the Treasury shall make the advance payment under this section of any premium tax credit allowed under section 36B of the Internal Revenue Code of 1986 to the issuer of a qualified health plan on a monthly basis (or such other periodic basis as the Secretary may provide).

(B) ISSUER RESPONSIBILITIES.—An issuer of a qualified health plan receiving an advance payment with respect to an individual enrolled in the plan shall—

(i) reduce the premium charged the insured for any period by the amount of the advance payment for the period;

(ii) notify the Exchange and the Secretary of such reduction;

(iii) include with each billing statement the amount by which the premium for the plan has been reduced by reason of the advance payment; and

(iv) in the case of any nonpayment of premiums by the insured—

(I) notify the Secretary of such nonpayment; and

(II) allow a 3-month grace period for nonpayment of premiums before discontinuing coverage.

(3) COST-SHARING REDUCTIONS.—The Secretary shall also notify the Secretary of the Treasury and the Exchange under paragraph (1) if an advance payment of the cost-sharing reductions under section 1402 is to be made to the issuer of any qualified health plan with respect to any individual enrolled in the plan. The Secretary of the Treasury shall make such advance payment at such time and in such amount as the Secretary specifies in the notice.

(d) NO FEDERAL PAYMENTS FOR INDIVIDUALS NOT LAWFULLY PRESENT.—Nothing in this subtitle or the

1 amendments made by this subtitle allows Federal pay-
2 ments, credits, or cost-sharing reductions for individuals
3 who are not lawfully present in the United States.

4 (e) STATE FLEXIBILITY.—Nothing in this subtitle or
5 the amendments made by this subtitle shall be construed
6 to prohibit a State from making payments to or on behalf
7 of an individual for coverage under a qualified health plan
8 offered through an Exchange that are in addition to any
9 credits or cost-sharing reductions allowable to the indi-
10 vidual under this subtitle and such amendments.

11 **SEC. 1413. STREAMLINING OF PROCEDURES FOR ENROLL-**
12 **MENT THROUGH AN EXCHANGE AND STATE**
13 **MEDICAID, CHIP, AND HEALTH SUBSIDY PRO-**
14 **GRAMS.**

15 (a) IN GENERAL.—The Secretary shall establish a
16 system meeting the requirements of this section under
17 which residents of each State may apply for enrollment
18 in, receive a determination of eligibility for participation
19 in, and continue participation in, applicable State health
20 subsidy programs. Such system shall ensure that if an in-
21 dividual applying to an Exchange is found through screen-
22 ing to be eligible for medical assistance under the State
23 medicaid plan under title XIX, or eligible for enrollment
24 under a State children's health insurance program

1 (CHIP) under title XXI of such Act, the individual is en-
2 rolled for assistance under such plan or program.
3 (b) REQUIREMENTS RELATING TO FORMS AND NO-
4 TICE.—
5 (1) REQUIREMENTS RELATING TO FORMS.—
6 (A) IN GENERAL.—The Secretary shall de-
7 velop and provide to each State a single,
8 streamlined form that—
9 (i) may be used to apply for all appli-
10 cable State health subsidy programs within
11 the State;
12 (ii) may be filed online, in person, by
13 mail, or by telephone;
14 (iii) may be filed with an Exchange or
15 with State officials operating one of the
16 other applicable State health subsidy pro-
17 grams; and
18 (iv) is structured to maximize an ap-
19 plicant's ability to complete the form satis-
20 factorily, taking into account the charac-
21 teristics of individuals who qualify for ap-
22 plicable State health subsidy programs.
23 (B) STATE AUTHORITY TO ESTABLISH
24 FORM.—A State may develop and use its own
25 single, streamlined form as an alternative to the

form developed under subparagraph (A) if the alternative form is consistent with standards promulgated by the Secretary under this section.

(C) SUPPLEMENTAL ELIGIBILITY FORMS.—The Secretary may allow a State to use a supplemental or alternative form in the case of individuals who apply for eligibility that is not determined on the basis of the household income (as defined in section 36B of the Internal Revenue Code of 1986).

(2) NOTICE.—The Secretary shall provide that an applicant filing a form under paragraph (1) shall receive notice of eligibility for an applicable State health subsidy program without any need to provide additional information or paperwork unless such information or paperwork is specifically required by law when information provided on the form is inconsistent with data used for the electronic verification under paragraph (3) or is otherwise insufficient to determine eligibility.

(c) REQUIREMENTS RELATING TO ELIGIBILITY BASED ON DATA EXCHANGES.—

(1) DEVELOPMENT OF SECURE INTERFACES.—Each State shall develop for all applicable State

1 health subsidy programs a secure, electronic inter-
2 face allowing an exchange of data (including infor-
3 mation contained in the application forms described
4 in subsection (b)) that allows a determination of eli-
5 gibility for all such programs based on a single ap-
6 plication. Such interface shall be compatible with the
7 method established for data verification under sec-
8 tion 1411(c)(4).

9 (2) DATA MATCHING PROGRAM.—Each applica-
10 ble State health subsidy program shall participate in
11 a data matching arrangement for determining eligi-
12 bility for participation in the program under para-
13 graph (3) that—

14 (A) provides access to data described in
15 paragraph (3);

16 (B) applies only to individuals who—

17 (i) receive assistance from an applica-
18 ble State health subsidy program; or

19 (ii) apply for such assistance—

20 (I) by filing a form described in
21 subsection (b); or

22 (II) by requesting a determina-
23 tion of eligibility and authorizing dis-
24 closure of the information described in
25 paragraph (3) to applicable State

1 health coverage subsidy programs for
2 purposes of determining and estab-
3 lishing eligibility; and
4 (C) consistent with standards promulgated
5 by the Secretary, including the privacy and data
6 security safeguards described in section 1942 of
7 the Social Security Act or that are otherwise
8 applicable to such programs.
9 (3) DETERMINATION OF ELIGIBILITY.—
10 (A) IN GENERAL.—Each applicable State
11 health subsidy program shall, to the maximum
12 extent practicable—
13 (i) establish, verify, and update eligi-
14 bility for participation in the program
15 using the data matching arrangement
16 under paragraph (2); and
17 (ii) determine such eligibility on the
18 basis of reliable, third party data, includ-
19 ing information described in sections 1137,
20 453(i), and 1942(a) of the Social Security
21 Act, obtained through such arrangement.
22 (B) EXCEPTION.—This paragraph shall
23 not apply in circumstances with respect to
24 which the Secretary determines that the admin-
25 istrative and other costs of use of the data

1 matching arrangement under paragraph (2)
2 outweigh its expected gains in accuracy, effi-
3 ciency, and program participation.
4 (4) SECRETARIAL STANDARDS.—The Secretary
5 shall, after consultation with persons in possession
6 of the data to be matched and representatives of ap-
7 plicable State health subsidy programs, promulgate
8 standards governing the timing, contents, and proce-
9 dures for data matching described in this subsection.
10 Such standards shall take into account administra-
11 tive and other costs and the value of data matching
12 to the establishment, verification, and updating of
13 eligibility for applicable State health subsidy pro-
14 grams.
15 (d) ADMINISTRATIVE AUTHORITY.—
16 (1) AGREEMENTS.—Subject to section 1411
17 and section 6103(l)(21) of the Internal Revenue
18 Code of 1986 and any other requirement providing
19 safeguards of privacy and data integrity, the Sec-
20 retary may establish model agreements, and enter
21 into agreements, for the sharing of data under this
22 section.
23 (2) AUTHORITY OF EXCHANGE TO CONTRACT
24 OUT.—Nothing in this section shall be construed
25 to—

1 (A) prohibit contractual arrangements
2 through which a State medicaid agency deter-
3 mines eligibility for all applicable State health
4 subsidy programs, but only if such agency com-
5 plies with the Secretary's requirements ensuring
6 reduced administrative costs, eligibility errors,
7 and disruptions in coverage; or
8 (B) change any requirement under title
9 XIX that eligibility for participation in a
10 State's medicaid program must be determined
11 by a public agency.
12 (e) APPLICABLE STATE HEALTH SUBSIDY PRO-
13 GRAM.—In this section, the term ''applicable State health
14 subsidy program'' means—
15 (1) the program under this title for the enroll-
16 ment in qualified health plans offered through an
17 Exchange, including the premium tax credits under
18 section 36B of the Internal Revenue Code of 1986
19 and cost-sharing reductions under section 1402;
20 (2) a State medicaid program under title XIX
21 of the Social Security Act;
22 (3) a State children's health insurance program
23 (CHIP) under title XXI of such Act; and
24 (4) a State program under section 1331 estab-
25 lishing qualified basic health plans.

SEC. 1414. DISCLOSURES TO CARRY OUT ELIGIBILITY REQUIREMENTS FOR CERTAIN PROGRAMS.

(a) DISCLOSURE OF TAXPAYER RETURN INFORMATION AND SOCIAL SECURITY NUMBERS.—

(1) TAXPAYER RETURN INFORMATION.—Subsection (l) of section 6103 of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:

"(21) DISCLOSURE OF RETURN INFORMATION TO CARRY OUT ELIGIBILITY REQUIREMENTS FOR CERTAIN PROGRAMS.—

"(A) IN GENERAL.—The Secretary, upon written request from the Secretary of Health and Human Services, shall disclose to officers, employees, and contractors of the Department of Health and Human Services return information of any taxpayer whose income is relevant in determining any premium tax credit under section 36B or any cost-sharing reduction under section 1402 of the Patient Protection and Affordable Care Act or eligibility for participation in a State medicaid program under title XIX of the Social Security Act, a State's children's health insurance program under title XXI of the Social Security Act, or a basic health program under section 1331 of Patient

1 Protection and Affordable Care Act. Such re-
2 turn information shall be limited to—
3 "(i) taxpayer identity information
4 with respect to such taxpayer,
5 "(ii) the filing status of such tax-
6 payer,
7 "(iii) the number of individuals for
8 whom a deduction is allowed under section
9 151 with respect to the taxpayer (including
10 the taxpayer and the taxpayer's spouse),
11 "(iv) the modified gross income (as
12 defined in section 36B) of such taxpayer
13 and each of the other individuals included
14 under clause (iii) who are required to file
15 a return of tax imposed by chapter 1 for
16 the taxable year,
17 "(v) such other information as is pre-
18 scribed by the Secretary by regulation as
19 might indicate whether the taxpayer is eli-
20 gible for such credit or reduction (and the
21 amount thereof), and
22 "(vi) the taxable year with respect to
23 which the preceding information relates or,
24 if applicable, the fact that such informa-
25 tion is not available.

"(B) INFORMATION TO EXCHANGE AND STATE AGENCIES.—The Secretary of Health and Human Services may disclose to an Exchange established under the Patient Protection and Affordable Care Act or its contractors, or to a State agency administering a State program described in subparagraph (A) or its contractors, any inconsistency between the information provided by the Exchange or State agency to the Secretary and the information provided to the Secretary under subparagraph (A).

"(C) RESTRICTION ON USE OF DISCLOSED INFORMATION.—Return information disclosed under subparagraph (A) or (B) may be used by officers, employees, and contractors of the Department of Health and Human Services, an Exchange, or a State agency only for the purposes of, and to the extent necessary in—

"(i) establishing eligibility for participation in the Exchange, and verifying the appropriate amount of, any credit or reduction described in subparagraph (A),

"(ii) determining eligibility for participation in the State programs described in subparagraph (A).".

(2) SOCIAL SECURITY NUMBERS.—Section 205(c)(2)(C) of the Social Security Act is amended by adding at the end the following new clause:

"(x) The Secretary of Health and Human Services, and the Exchanges established under section 1311 of the Patient Protection and Affordable Care Act, are authorized to collect and use the names and social security account numbers of individuals as required to administer the provisions of, and the amendments made by, the such Act.".

(b) CONFIDENTIALITY AND DISCLOSURE.—Paragraph (3) of section 6103(a) of such Code is amended by striking "or (20)" and inserting "(20), or (21)".

(c) PROCEDURES AND RECORDKEEPING RELATED TO DISCLOSURES.—Paragraph (4) of section 6103(p) of such Code is amended—

(1) by inserting ", or any entity described in subsection (l)(21)," after "or (20)" in the matter preceding subparagraph (A),

(2) by inserting ''or any entity described in subsection (l)(21),'' after ''or (o)(1)(A)'' in subparagraph (F)(ii), and

(3) by inserting ''or any entity described in subsection (l)(21),'' after ''or (20)'' both places it appears in the matter after subparagraph (F).

(d) UNAUTHORIZED DISCLOSURE OR INSPECTION.—Paragraph (2) of section 7213(a) of such Code is amended by striking ''or (20)'' and inserting ''(20), or (21)''.

SEC. 1415. PREMIUM TAX CREDIT AND COST-SHARING REDUCTION PAYMENTS DISREGARDED FOR FEDERAL AND FEDERALLY-ASSISTED PROGRAMS.

For purposes of determining the eligibility of any individual for benefits or assistance, or the amount or extent of benefits or assistance, under any Federal program or under any State or local program financed in whole or in part with Federal funds—

(1) any credit or refund allowed or made to any individual by reason of section 36B of the Internal Revenue Code of 1986 (as added by section 1401) shall not be taken into account as income and shall not be taken into account as resources for the month of receipt and the following 2 months; and

(2) any cost-sharing reduction payment or advance payment of the credit allowed under such section 36B that is made under section 1402 or 1412 shall be treated as made to the qualified health plan in which an individual is enrolled and not to that individual.

PART II—SMALL BUSINESS TAX CREDIT

SEC. 1421. CREDIT FOR EMPLOYEE HEALTH INSURANCE EXPENSES OF SMALL BUSINESSES.

(a) IN GENERAL.—Subpart D of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to business-related credits) is amended by inserting after section 45Q the following:

"SEC. 45R. EMPLOYEE HEALTH INSURANCE EXPENSES OF SMALL EMPLOYERS.

"(a) GENERAL RULE.—For purposes of section 38, in the case of an eligible small employer, the small employer health insurance credit determined under this section for any taxable year in the credit period is the amount determined under subsection (b).

"(b) HEALTH INSURANCE CREDIT AMOUNT.—Subject to subsection (c), the amount determined under this subsection with respect to any eligible small employer is equal to 50 percent (35 percent in the case of a tax-exempt eligible small employer) of the lesser of—

1 "(1) the aggregate amount of nonelective con-
2 tributions the employer made on behalf of its em-
3 ployees during the taxable year under the arrange-
4 ment described in subsection (d)(4) for premiums
5 for qualified health plans offered by the employer to
6 its employees through an Exchange, or
7 "(2) the aggregate amount of nonelective con-
8 tributions which the employer would have made dur-
9 ing the taxable year under the arrangement if each
10 employee taken into account under paragraph (1)
11 had enrolled in a qualified health plan which had a
12 premium equal to the average premium (as deter-
13 mined by the Secretary of Health and Human Serv-
14 ices) for the small group market in the rating area
15 in which the employee enrolls for coverage.
16 "(c) PHASEOUT OF CREDIT AMOUNT BASED ON
17 NUMBER OF EMPLOYEES AND AVERAGE WAGES.—The
18 amount of the credit determined under subsection (b)
19 without regard to this subsection shall be reduced (but not
20 below zero) by the sum of the following amounts:
21 "(1) Such amount multiplied by a fraction the
22 numerator of which is the total number of full-time
23 equivalent employees of the employer in excess of 10
24 and the denominator of which is 15.

1 "(2) Such amount multiplied by a fraction the
2 numerator of which is the average annual wages of
3 the employer in excess of the dollar amount in effect
4 under subsection (d)(3)(B) and the denominator of
5 which is such dollar amount.
6 "(d) ELIGIBLE SMALL EMPLOYER.—For purposes of
7 this section—
8 "(1) IN GENERAL.—The term 'eligible small
9 employer' means, with respect to any taxable year,
10 an employer—
11 "(A) which has no more than 25 full-time
12 equivalent employees for the taxable year,
13 "(B) the average annual wages of which do
14 not exceed an amount equal to twice the dollar
15 amount in effect under paragraph (3)(B) for
16 the taxable year, and
17 "(C) which has in effect an arrangement
18 described in paragraph (4).
19 "(2) FULL-TIME EQUIVALENT EMPLOYEES.—
20 "(A) IN GENERAL.—The term 'full-time
21 equivalent employees' means a number of em-
22 ployees equal to the number determined by di-
23 viding—
24 "(i) the total number of hours of serv-
25 ice for which wages were paid by the em-

1 ployer to employees during the taxable
2 year, by
3 "(ii) 2,080.
4 Such number shall be rounded to the next low-
5 est whole number if not otherwise a whole num-
6 ber.
7 "(B) EXCESS HOURS NOT COUNTED.—If
8 an employee works in excess of 2,080 hours of
9 service during any taxable year, such excess
10 shall not be taken into account under subpara-
11 graph (A).
12 "(C) HOURS OF SERVICE.—The Secretary,
13 in consultation with the Secretary of Labor,
14 shall prescribe such regulations, rules, and
15 guidance as may be necessary to determine the
16 hours of service of an employee, including rules
17 for the application of this paragraph to employ-
18 ees who are not compensated on an hourly
19 basis.
20 "(3) AVERAGE ANNUAL WAGES.—
21 "(A) IN GENERAL.—The average annual
22 wages of an eligible small employer for any tax-
23 able year is the amount determined by divid-
24 ing—

"(i) the aggregate amount of wages which were paid by the employer to employees during the taxable year, by

"(ii) the number of full-time equivalent employees of the employee determined under paragraph (2) for the taxable year.

Such amount shall be rounded to the next lowest multiple of $1,000 if not otherwise such a multiple.

"(B) DOLLAR AMOUNT.—For purposes of paragraph (1)(B)—

"(i) 2011, 2012, AND 2013.—The dollar amount in effect under this paragraph for taxable years beginning in 2011, 2012, or 2013 is $20,000.

"(ii) SUBSEQUENT YEARS.—In the case of a taxable year beginning in a calendar year after 2013, the dollar amount in effect under this paragraph shall be equal to $20,000, multiplied by the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting 'calendar year 2012' for 'calendar year 1992' in subparagraph (B) thereof.

1 "(4) CONTRIBUTION ARRANGEMENT.—An ar-
2 rangement is described in this paragraph if it re-
3 quires an eligible small employer to make a nonelec-
4 tive contribution on behalf of each employee who en-
5 rolls in a qualified health plan offered to employees
6 by the employer through an exchange in an amount
7 equal to a uniform percentage (not less than 50 per-
8 cent) of the premium cost of the qualified health
9 plan.

10 "(5) SEASONAL WORKER HOURS AND WAGES
11 NOT COUNTED.—For purposes of this subsection—

12 "(A) IN GENERAL.—The number of hours
13 of service worked by, and wages paid to, a sea-
14 sonal worker of an employer shall not be taken
15 into account in determining the full-time equiv-
16 alent employees and average annual wages of
17 the employer unless the worker works for the
18 employer on more than 120 days during the
19 taxable year.

20 "(B) DEFINITION OF SEASONAL WORK-
21 ER.—The term 'seasonal worker' means a work-
22 er who performs labor or services on a seasonal
23 basis as defined by the Secretary of Labor, in-
24 cluding workers covered by section 500.20(s)(1)
25 of title 29, Code of Federal Regulations and re-

tail workers employed exclusively during holiday seasons.

"(e) OTHER RULES AND DEFINITIONS.—For purposes of this section—

"(1) EMPLOYEE.—

"(A) CERTAIN EMPLOYEES EXCLUDED.—The term 'employee' shall not include—

"(i) an employee within the meaning of section 401(c)(1),

"(ii) any 2-percent shareholder (as defined in section 1372(b)) of an eligible small business which is an S corporation,

"(iii) any 5-percent owner (as defined in section 416(i)(1)(B)(i)) of an eligible small business, or

"(iv) any individual who bears any of the relationships described in subparagraphs (A) through (G) of section 152(d)(2) to, or is a dependent described in section 152(d)(2)(H) of, an individual described in clause (i), (ii), or (iii).

"(B) LEASED EMPLOYEES.—The term 'employee' shall include a leased employee within the meaning of section 414(n).

1 "(2) CREDIT PERIOD.—The term 'credit period'
2 means, with respect to any eligible small employer,
3 the 2-consecutive-taxable year period beginning with
4 the 1st taxable year in which the employer (or any
5 predecessor) offers 1 or more qualified health plans
6 to its employees through an Exchange.

7 "(3) NONELECTIVE CONTRIBUTION.—The term
8 'nonelective contribution' means an employer con-
9 tribution other than an employer contribution pursu-
10 ant to a salary reduction arrangement.

11 "(4) WAGES.—The term 'wages' has the mean-
12 ing given such term by section 3121(a) (determined
13 without regard to any dollar limitation contained in
14 such section).

15 "(5) AGGREGATION AND OTHER RULES MADE
16 APPLICABLE.—

17 "(A) AGGREGATION RULES.—All employ-
18 ers treated as a single employer under sub-
19 section (b), (c), (m), or (o) of section 414 shall
20 be treated as a single employer for purposes of
21 this section.

22 "(B) OTHER RULES.—Rules similar to the
23 rules of subsections (c), (d), and (e) of section
24 52 shall apply.

1 "(f) CREDIT MADE AVAILABLE TO TAX-EXEMPT ELI-
2 GIBLE SMALL EMPLOYERS.—
3 "(1) IN GENERAL.—In the case of a tax-exempt
4 eligible small employer, there shall be treated as a
5 credit allowable under subpart C (and not allowable
6 under this subpart) the lesser of—
7 "(A) the amount of the credit determined
8 under this section with respect to such em-
9 ployer, or
10 "(B) the amount of the payroll taxes of the
11 employer during the calendar year in which the
12 taxable year begins.
13 "(2) TAX-EXEMPT ELIGIBLE SMALL EM-
14 PLOYER.—For purposes of this section, the term
15 'tax-exempt eligible small employer' means an eligi-
16 ble small employer which is any organization de-
17 scribed in section 501(c) which is exempt from tax-
18 ation under section 501(a).
19 "(3) PAYROLL TAXES.—For purposes of this
20 subsection—
21 "(A) IN GENERAL.—The term 'payroll
22 taxes' means—
23 "(i) amounts required to be withheld
24 from the employees of the tax-exempt eligi-
25 ble small employer under section 3401(a),

"(ii) amounts required to be withheld from such employees under section 3101(b), and

"(iii) amounts of the taxes imposed on the tax-exempt eligible small employer under section 3111(b).

"(B) SPECIAL RULE.—A rule similar to the rule of section 24(d)(2)(C) shall apply for purposes of subparagraph (A).

"(g) APPLICATION OF SECTION FOR CALENDAR YEARS 2011, 2012, AND 2013.—In the case of any taxable year beginning in 2011, 2012, or 2013, the following modifications to this section shall apply in determining the amount of the credit under subsection (a):

"(1) NO CREDIT PERIOD REQUIRED.—The credit shall be determined without regard to whether the taxable year is in a credit period and for purposes of applying this section to taxable years beginning after 2013, no credit period shall be treated as beginning with a taxable year beginning before 2014.

"(2) AMOUNT OF CREDIT.—The amount of the credit determined under subsection (b) shall be determined—

1 "(A) by substituting '35 percent (25 per-
2 cent in the case of a tax-exempt eligible small
3 employer)' for '50 percent (35 percent in the
4 case of a tax-exempt eligible small employer)',
5 "(B) by reference to an eligible small em-
6 ployer's nonelective contributions for premiums
7 paid for health insurance coverage (within the
8 meaning of section 9832(b)(1)) of an employee,
9 and
10 "(C) by substituting for the average pre-
11 mium determined under subsection (b)(2) the
12 amount the Secretary of Health and Human
13 Services determines is the average premium for
14 the small group market in the State in which
15 the employer is offering health insurance cov-
16 erage (or for such area within the State as is
17 specified by the Secretary).
18 "(3) CONTRIBUTION ARRANGEMENT.—An ar-
19 rangement shall not fail to meet the requirements of
20 subsection (d)(4) solely because it provides for the
21 offering of insurance outside of an Exchange.
22 "(h) INSURANCE DEFINITIONS.—Any term used in
23 this section which is also used in the Public Health Service
24 Act or subtitle A of title I of the Patient Protection and

1 Affordable Care Act shall have the meaning given such
2 term by such Act or subtitle.

3 ''(i) REGULATIONS.—The Secretary shall prescribe
4 such regulations as may be necessary to carry out the pro-
5 visions of this section, including regulations to prevent the
6 avoidance of the 2-year limit on the credit period through
7 the use of successor entities and the avoidance of the limi-
8 tations under subsection (c) through the use of multiple
9 entities.''.

10 (b) CREDIT TO BE PART OF GENERAL BUSINESS
11 CREDIT.—Section 38(b) of the Internal Revenue Code of
12 1986 (relating to current year business credit) is amended
13 by striking ''plus'' at the end of paragraph (34), by strik-
14 ing the period at the end of paragraph (35) and inserting
15 '', plus'', and by inserting after paragraph (35) the fol-
16 lowing:

17 ''(36) the small employer health insurance cred-
18 it determined under section 45R.''.

19 (c) CREDIT ALLOWED AGAINST ALTERNATIVE MIN-
20 IMUM TAX.—Section 38(c)(4)(B) of the Internal Revenue
21 Code of 1986 (defining specified credits) is amended by
22 redesignating clauses (vi), (vii), and (viii) as clauses (vii),
23 (viii), and (ix), respectively, and by inserting after clause
24 (v) the following new clause:

"(vi) the credit determined under section 45R,".

(d) DISALLOWANCE OF DEDUCTION FOR CERTAIN EXPENSES FOR WHICH CREDIT ALLOWED.—

(1) IN GENERAL.—Section 280C of the Internal Revenue Code of 1986 (relating to disallowance of deduction for certain expenses for which credit allowed), as amended by section 1401(b), is amended by adding at the end the following new subsection:

"(h) CREDIT FOR EMPLOYEE HEALTH INSURANCE EXPENSES OF SMALL EMPLOYERS.—No deduction shall be allowed for that portion of the premiums for qualified health plans (as defined in section 1301(a) of the Patient Protection and Affordable Care Act), or for health insurance coverage in the case of taxable years beginning in 2011, 2012, or 2013, paid by an employer which is equal to the amount of the credit determined under section 45R(a) with respect to the premiums.".

(2) DEDUCTION FOR EXPIRING CREDITS.—Section 196(c) of such Code is amended by striking "and" at the end of paragraph (12), by striking the period at the end of paragraph (13) and inserting ", and", and by adding at the end the following new paragraph:

"(14) the small employer health insurance credit determined under section 45R(a).".

(e) CLERICAL AMENDMENT.—The table of sections for subpart D of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by adding at the end the following:

"Sec. 45R. Employee health insurance expenses of small employers.".

(f) EFFECTIVE DATES.—

(1) IN GENERAL.—The amendments made by this section shall apply to amounts paid or incurred in taxable years beginning after December 31, 2010.

(2) MINIMUM TAX.—The amendments made by subsection (c) shall apply to credits determined under section 45R of the Internal Revenue Code of 1986 in taxable years beginning after December 31, 2010, and to carrybacks of such credits.

Subtitle F—Shared Responsibility for Health Care

PART I—INDIVIDUAL RESPONSIBILITY

SEC. 1501. REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.

(a) FINDINGS.—Congress makes the following findings:

(1) IN GENERAL.—The individual responsibility requirement provided for in this section (in this subsection referred to as the "requirement") is commer-

1 cial and economic in nature, and substantially af-
2 fects interstate commerce, as a result of the effects
3 described in paragraph (2).

4 (2) EFFECTS ON THE NATIONAL ECONOMY AND
5 INTERSTATE COMMERCE.—The effects described in
6 this paragraph are the following:

7 (A) The requirement regulates activity that
8 is commercial and economic in nature: economic
9 and financial decisions about how and when
10 health care is paid for, and when health insur-
11 ance is purchased.

12 (B) Health insurance and health care serv-
13 ices are a significant part of the national econ-
14 omy. National health spending is projected to
15 increase from $2,500,000,000,000, or 17.6 per-
16 cent of the economy, in 2009 to
17 $4,700,000,000,000 in 2019. Private health in-
18 surance spending is projected to be
19 $854,000,000,000 in 2009, and pays for med-
20 ical supplies, drugs, and equipment that are
21 shipped in interstate commerce. Since most
22 health insurance is sold by national or regional
23 health insurance companies, health insurance is
24 sold in interstate commerce and claims pay-
25 ments flow through interstate commerce.

(C) The requirement, together with the other provisions of this Act, will add millions of new consumers to the health insurance market, increasing the supply of, and demand for, health care services. According to the Congressional Budget Office, the requirement will increase the number and share of Americans who are insured.

(D) The requirement achieves near-universal coverage by building upon and strengthening the private employer-based health insurance system, which covers 176,000,000 Americans nationwide. In Massachusetts, a similar requirement has strengthened private employer-based coverage: despite the economic downturn, the number of workers offered employer-based coverage has actually increased.

(E) Half of all personal bankruptcies are caused in part by medical expenses. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will improve financial security for families.

(F) Under the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et

1 seq.), the Public Health Service Act (42 U.S.C.
2 201 et seq.), and this Act, the Federal Govern-
3 ment has a significant role in regulating health
4 insurance which is in interstate commerce.
5 (G) Under sections 2704 and 2705 of the
6 Public Health Service Act (as added by section
7 1201 of this Act), if there were no requirement,
8 many individuals would wait to purchase health
9 insurance until they needed care. By signifi-
10 cantly increasing health insurance coverage, the
11 requirement, together with the other provisions
12 of this Act, will minimize this adverse selection
13 and broaden the health insurance risk pool to
14 include healthy individuals, which will lower
15 health insurance premiums. The requirement is
16 essential to creating effective health insurance
17 markets in which improved health insurance
18 products that are guaranteed issue and do not
19 exclude coverage of pre-existing conditions can
20 be sold.
21 (H) Administrative costs for private health
22 insurance, which were $90,000,000,000 in
23 2006, are 26 to 30 percent of premiums in the
24 current individual and small group markets. By
25 significantly increasing health insurance cov-

erage and the size of purchasing pools, which will increase economies of scale, the requirement, together with the other provisions of this Act, will significantly reduce administrative costs and lower health insurance premiums. The requirement is essential to creating effective health insurance markets that do not require underwriting and eliminate its associated administrative costs.

(3) SUPREME COURT RULING.—In United States v. South-Eastern Underwriters Association (322 U.S. 533 (1944)), the Supreme Court of the United States ruled that insurance is interstate commerce subject to Federal regulation.

(b) IN GENERAL.—Subtitle D of the Internal Revenue Code of 1986 is amended by adding at the end the following new chapter:

"CHAPTER 48—MAINTENANCE OF MINIMUM ESSENTIAL COVERAGE

"Sec. 5000A. Requirement to maintain minimum essential coverage.

"SEC. 5000A. REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.

"(a) REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.—An applicable individual shall for each month beginning after 2013 ensure that the individual,

1 and any dependent of the individual who is an applicable
2 individual, is covered under minimum essential coverage
3 for such month.

4 "(b) SHARED RESPONSIBILITY PAYMENT.—

5 "(1) IN GENERAL.—If an applicable individual
6 fails to meet the requirement of subsection (a) for
7 1 or more months during any calendar year begin-
8 ning after 2013, then, except as provided in sub-
9 section (d), there is hereby imposed a penalty with
10 respect to the individual in the amount determined
11 under subsection (c).

12 "(2) INCLUSION WITH RETURN.—Any penalty
13 imposed by this section with respect to any month
14 shall be included with a taxpayer's return under
15 chapter 1 for the taxable year which includes such
16 month.

17 "(3) PAYMENT OF PENALTY.—If an individual
18 with respect to whom a penalty is imposed by this
19 section for any month—

20 "(A) is a dependent (as defined in section
21 152) of another taxpayer for the other tax-
22 payer's taxable year including such month, such
23 other taxpayer shall be liable for such penalty,
24 or

"(B) files a joint return for the taxable year including such month, such individual and the spouse of such individual shall be jointly liable for such penalty.

"(c) AMOUNT OF PENALTY.—

"(1) IN GENERAL.—The penalty determined under this subsection for any month with respect to any individual is an amount equal to 1/12 of the applicable dollar amount for the calendar year.

"(2) DOLLAR LIMITATION.—The amount of the penalty imposed by this section on any taxpayer for any taxable year with respect to all individuals for whom the taxpayer is liable under subsection (b)(3) shall not exceed an amount equal to 300 percent the applicable dollar amount (determined without regard to paragraph (3)(C)) for the calendar year with or within which the taxable year ends.

"(3) APPLICABLE DOLLAR AMOUNT.—For purposes of paragraph (1)—

"(A) IN GENERAL.—Except as provided in subparagraphs (B) and (C), the applicable dollar amount is $750.

"(B) PHASE IN.—The applicable dollar amount is $95 for 2014 and $350 for 2015.

"(C) SPECIAL RULE FOR INDIVIDUALS UNDER AGE 18.—If an applicable individual has not attained the age of 18 as of the beginning of a month, the applicable dollar amount with respect to such individual for the month shall be equal to one-half of the applicable dollar amount for the calendar year in which the month occurs.

"(D) INDEXING OF AMOUNT.—In the case of any calendar year beginning after 2016, the applicable dollar amount shall be equal to $750, increased by an amount equal to—

"(i) $750, multiplied by

"(ii) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting 'calendar year 2015' for 'calendar year 1992' in subparagraph (B) thereof.

If the amount of any increase under clause (i) is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.

"(4) TERMS RELATING TO INCOME AND FAMILIES.—For purposes of this section—

"(A) FAMILY SIZE.—The family size involved with respect to any taxpayer shall be

equal to the number of individuals for whom the taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year.

"(B) HOUSEHOLD INCOME.—The term 'household income' means, with respect to any taxpayer for any taxable year, an amount equal to the sum of—

"(i) the modified gross income of the taxpayer, plus

"(ii) the aggregate modified gross incomes of all other individuals who—

"(I) were taken into account in determining the taxpayer's family size under paragraph (1), and

"(II) were required to file a return of tax imposed by section 1 for the taxable year.

"(C) MODIFIED GROSS INCOME.—The term 'modified gross income' means gross income—

"(i) decreased by the amount of any deduction allowable under paragraph (1), (3), (4), or (10) of section 62(a),

"(ii) increased by the amount of interest received or accrued during the taxable year which is exempt from tax imposed by this chapter, and

"(iii) determined without regard to sections 911, 931, and 933.

"(D) POVERTY LINE.—

"(i) IN GENERAL.—The term 'poverty line' has the meaning given that term in section 2110(c)(5) of the Social Security Act (42 U.S.C. 1397jj(c)(5)).

"(ii) POVERTY LINE USED.—In the case of any taxable year ending with or within a calendar year, the poverty line used shall be the most recently published poverty line as of the 1st day of such calendar year.

"(d) APPLICABLE INDIVIDUAL.—For purposes of this section—

"(1) IN GENERAL.—The term 'applicable individual' means, with respect to any month, an individual other than an individual described in paragraph (2), (3), or (4).

"(2) RELIGIOUS EXEMPTIONS.—

"(A) RELIGIOUS CONSCIENCE EXEMPTION.—Such term shall not include any individual for any month if such individual has in effect an exemption under section 1311(d)(4)(H) of the Patient Protection and Affordable Care Act which certifies that such individual is a member of a recognized religious sect or division thereof described in section 1402(g)(1) and an adherent of established tenets or teachings of such sect or division as described in such section.

"(B) HEALTH CARE SHARING MINISTRY.—

"(i) IN GENERAL.—Such term shall not include any individual for any month if such individual is a member of a health care sharing ministry for the month.

"(ii) HEALTH CARE SHARING MINISTRY.—The term 'health care sharing ministry' means an organization—

"(I) which is described in section 501(c)(3) and is exempt from taxation under section 501(a),

"(II) members of which share a common set of ethical or religious beliefs and share medical expenses

among members in accordance with those beliefs and without regard to the State in which a member resides or is employed,

"(III) members of which retain membership even after they develop a medical condition,

"(IV) which (or a predecessor of which) has been in existence at all times since December 31, 1999, and medical expenses of its members have been shared continuously and without interruption since at least December 31, 1999, and

"(V) which conducts an annual audit which is performed by an independent certified public accounting firm in accordance with generally accepted accounting principles and which is made available to the public upon request.

"(3) INDIVIDUALS NOT LAWFULLY PRESENT.—Such term shall not include an individual for any month if for the month the individual is not a citizen

1 or national of the United States or an alien lawfully
2 present in the United States.
3 "(4) INCARCERATED INDIVIDUALS.—Such term
4 shall not include an individual for any month if for
5 the month the individual is incarcerated, other than
6 incarceration pending the disposition of charges.
7 "(e) EXEMPTIONS.—No penalty shall be imposed
8 under subsection (a) with respect to—
9 "(1) INDIVIDUALS WHO CANNOT AFFORD COV-
10 ERAGE.—
11 "(A) IN GENERAL.—Any applicable indi-
12 vidual for any month if the applicable individ-
13 ual's required contribution (determined on an
14 annual basis) for coverage for the month ex-
15 ceeds 8 percent of such individual's household
16 income for the taxable year described in section
17 1412(b)(1)(B) of the Patient Protection and
18 Affordable Care Act. For purposes of applying
19 this subparagraph, the taxpayer's household in-
20 come shall be increased by any exclusion from
21 gross income for any portion of the required
22 contribution made through a salary reduction
23 arrangement.

1 "(B) REQUIRED CONTRIBUTION.—For
2 purposes of this paragraph, the term 'required
3 contribution' means—
4 "(i) in the case of an individual eligi-
5 ble to purchase minimum essential cov-
6 erage consisting of coverage through an el-
7 igible-employer-sponsored plan, the portion
8 of the annual premium which would be
9 paid by the individual (without regard to
10 whether paid through salary reduction or
11 otherwise) for self-only coverage, or
12 "(ii) in the case of an individual eligi-
13 ble only to purchase minimum essential
14 coverage described in subsection (f)(1)(C),
15 the annual premium for the lowest cost
16 bronze plan available in the individual
17 market through the Exchange in the State
18 in the rating area in which the individual
19 resides (without regard to whether the in-
20 dividual purchased a qualified health plan
21 through the Exchange), reduced by the
22 amount of the credit allowable under sec-
23 tion 36B for the taxable year (determined
24 as if the individual was covered by a quali-

fied health plan offered through the Exchange for the entire taxable year).

"(C) SPECIAL RULES FOR INDIVIDUALS RELATED TO EMPLOYEES.—For purposes of subparagraph (B)(i), if an applicable individual is eligible for minimum essential coverage through an employer by reason of a relationship to an employee, the determination shall be made by reference to the affordability of the coverage to the employee.

"(D) INDEXING.—In the case of plan years beginning in any calendar year after 2014, subparagraph (A) shall be applied by substituting for '8 percent' the percentage the Secretary of Health and Human Services determines reflects the excess of the rate of premium growth between the preceding calendar year and 2013 over the rate of income growth for such period.

"(2) TAXPAYERS WITH INCOME UNDER 100 PERCENT OF POVERTY LINE.—Any applicable individual for any month during a calendar year if the individual's household income for the taxable year described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act is less than 100 percent of the poverty line for the size of the family

1 involved (determined in the same manner as under
2 subsection (b)(4)).
3 "(3) MEMBERS OF INDIAN TRIBES.—Any appli-
4 cable individual for any month during which the in-
5 dividual is a member of an Indian tribe (as defined
6 in section 45A(c)(6)).
7 "(4) MONTHS DURING SHORT COVERAGE
8 GAPS.—
9 "(A) IN GENERAL.—Any month the last
10 day of which occurred during a period in which
11 the applicable individual was not covered by
12 minimum essential coverage for a continuous
13 period of less than 3 months.
14 "(B) SPECIAL RULES.—For purposes of
15 applying this paragraph—
16 "(i) the length of a continuous period
17 shall be determined without regard to the
18 calendar years in which months in such pe-
19 riod occur,
20 "(ii) if a continuous period is greater
21 than the period allowed under subpara-
22 graph (A), no exception shall be provided
23 under this paragraph for any month in the
24 period, and

1 "(iii) if there is more than 1 contin-
2 uous period described in subparagraph (A)
3 covering months in a calendar year, the ex-
4 ception provided by this paragraph shall
5 only apply to months in the first of such
6 periods.
7 The Secretary shall prescribe rules for the col-
8 lection of the penalty imposed by this section in
9 cases where continuous periods include months
10 in more than 1 taxable year.
11 "(5) HARDSHIPS.—Any applicable individual
12 who for any month is determined by the Secretary
13 of Health and Human Services under section
14 1311(d)(4)(H) to have suffered a hardship with re-
15 spect to the capability to obtain coverage under a
16 qualified health plan.
17 "(f) MINIMUM ESSENTIAL COVERAGE.—For pur-
18 poses of this section—
19 "(1) IN GENERAL.—The term 'minimum essen-
20 tial coverage' means any of the following:
21 "(A) GOVERNMENT SPONSORED PRO-
22 GRAMS.—Coverage under—
23 "(i) the Medicare program under part
24 A of title XVIII of the Social Security Act,

1 "(ii) the Medicaid program under title
2 XIX of the Social Security Act,
3 "(iii) the CHIP program under title
4 XXI of the Social Security Act,
5 "(iv) the TRICARE for Life program,
6 "(v) the veteran's health care program
7 under chapter 17 of title 38, United States
8 Code, or
9 "(vi) a health plan under section
10 2504(e) of title 22, United States Code
11 (relating to Peace Corps volunteers).
12 "(B) EMPLOYER-SPONSORED PLAN.—Cov-
13 erage under an eligible employer-sponsored
14 plan.
15 "(C) PLANS IN THE INDIVIDUAL MAR-
16 KET.—Coverage under a health plan offered in
17 the individual market within a State.
18 "(D) GRANDFATHERED HEALTH PLAN.—
19 Coverage under a grandfathered health plan.
20 "(E) OTHER COVERAGE.—Such other
21 health benefits coverage, such as a State health
22 benefits risk pool, as the Secretary of Health
23 and Human Services, in coordination with the
24 Secretary, recognizes for purposes of this sub-
25 section.

1 "(2) ELIGIBLE EMPLOYER-SPONSORED PLAN.—
2 The term 'eligible employer-sponsored plan' means,
3 with respect to any employee, a group health plan or
4 group health insurance coverage offered by an em-
5 ployer to the employee which is—
6 "(A) a governmental plan (within the
7 meaning of section 2791(d)(8) of the Public
8 Health Service Act), or
9 "(B) any other plan or coverage offered in
10 the small or large group market within a State.
11 Such term shall include a grandfathered health plan
12 described in paragraph (1)(D) offered in a group
13 market.
14 "(3) EXCEPTED BENEFITS NOT TREATED AS
15 MINIMUM ESSENTIAL COVERAGE.—The term 'min-
16 imum essential coverage' shall not include health in-
17 surance coverage which consists of coverage of ex-
18 cepted benefits—
19 "(A) described in paragraph (1) of sub-
20 section (c) of section 2791 of the Public Health
21 Service Act; or
22 "(B) described in paragraph (2), (3), or
23 (4) of such subsection if the benefits are pro-
24 vided under a separate policy, certificate, or
25 contract of insurance.

"(4) INDIVIDUALS RESIDING OUTSIDE UNITED STATES OR RESIDENTS OF TERRITORIES.—Any applicable individual shall be treated as having minimum essential coverage for any month—

"(A) if such month occurs during any period described in subparagraph (A) or (B) of section 911(d)(1) which is applicable to the individual, or

"(B) if such individual is a bona fide resident of any possession of the United States (as determined under section 937(a)) for such month.

"(5) INSURANCE-RELATED TERMS.—Any term used in this section which is also used in title I of the Patient Protection and Affordable Care Act shall have the same meaning as when used in such title.

"(g) ADMINISTRATION AND PROCEDURE.—

"(1) IN GENERAL.—The penalty provided by this section shall be paid upon notice and demand by the Secretary, and except as provided in paragraph (2), shall be assessed and collected in the same manner as an assessable penalty under subchapter B of chapter 68.

"(2) SPECIAL RULES.—Notwithstanding any other provision of law—

"(A) WAIVER OF CRIMINAL PENALTIES.—In the case of any failure by a taxpayer to timely pay any penalty imposed by this section, such taxpayer shall not be subject to any criminal prosecution or penalty with respect to such failure.

"(B) LIMITATIONS ON LIENS AND LEVIES.—The Secretary shall not—

"(i) file notice of lien with respect to any property of a taxpayer by reason of any failure to pay the penalty imposed by this section, or

"(ii) levy on any such property with respect to such failure.".

(c) CLERICAL AMENDMENT.—The table of chapters for subtitle D of the Internal Revenue Code of 1986 is amended by inserting after the item relating to chapter 47 the following new item:

"CHAPTER 48—MAINTENANCE OF MINIMUM ESSENTIAL COVERAGE.".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years ending after December 31, 2013.

SEC. 1502. REPORTING OF HEALTH INSURANCE COVERAGE.

(a) IN GENERAL.—Part III of subchapter A of chapter 61 of the Internal Revenue Code of 1986 is amended by inserting after subpart C the following new subpart:

1 **"Subpart D—Information Regarding Health**
2 **Insurance Coverage**

"Sec. 6055. Reporting of health insurance coverage.

3 **"SEC. 6055. REPORTING OF HEALTH INSURANCE COV-**
4 **ERAGE.**

5 "(a) IN GENERAL.—Every person who provides min-
6 imum essential coverage to an individual during a calendar
7 year shall, at such time as the Secretary may prescribe,
8 make a return described in subsection (b).

9 "(b) FORM AND MANNER OF RETURN.—

10 "(1) IN GENERAL.—A return is described in
11 this subsection if such return—

12 "(A) is in such form as the Secretary may
13 prescribe, and

14 "(B) contains—

15 "(i) the name, address and TIN of
16 the primary insured and the name and
17 TIN of each other individual obtaining cov-
18 erage under the policy,

19 "(ii) the dates during which such indi-
20 vidual was covered under minimum essen-
21 tial coverage during the calendar year,

22 "(iii) in the case of minimum essential
23 coverage which consists of health insurance
24 coverage, information concerning—

1 "(I) whether or not the coverage
2 is a qualified health plan offered
3 through an Exchange established
4 under section 1311 of the Patient
5 Protection and Affordable Care Act,
6 and
7 "(II) in the case of a qualified
8 health plan, the amount (if any) of
9 any advance payment under section
10 1412 of the Patient Protection and
11 Affordable Care Act of any cost-shar-
12 ing reduction under section 1402 of
13 such Act or of any premium tax credit
14 under section 36B with respect to
15 such coverage, and
16 "(iv) such other information as the
17 Secretary may require.
18 "(2) INFORMATION RELATING TO EMPLOYER-
19 PROVIDED COVERAGE.—If minimum essential cov-
20 erage provided to an individual under subsection (a)
21 consists of health insurance coverage of a health in-
22 surance issuer provided through a group health plan
23 of an employer, a return described in this subsection
24 shall include—

"(A) the name, address, and employer identification number of the employer maintaining the plan,

"(B) the portion of the premium (if any) required to be paid by the employer, and

"(C) if the health insurance coverage is a qualified health plan in the small group market offered through an Exchange, such other information as the Secretary may require for administration of the credit under section 45R (relating to credit for employee health insurance expenses of small employers).

"(c) STATEMENTS TO BE FURNISHED TO INDIVIDUALS WITH RESPECT TO WHOM INFORMATION IS REPORTED.—

"(1) IN GENERAL.—Every person required to make a return under subsection (a) shall furnish to each individual whose name is required to be set forth in such return a written statement showing—

"(A) the name and address of the person required to make such return and the phone number of the information contact for such person, and

"(B) the information required to be shown on the return with respect to such individual.

"(2) TIME FOR FURNISHING STATEMENTS.—The written statement required under paragraph (1) shall be furnished on or before January 31 of the year following the calendar year for which the return under subsection (a) was required to be made.

"(d) COVERAGE PROVIDED BY GOVERNMENTAL UNITS.—In the case of coverage provided by any governmental unit or any agency or instrumentality thereof, the officer or employee who enters into the agreement to provide such coverage (or the person appropriately designated for purposes of this section) shall make the returns and statements required by this section.

"(e) MINIMUM ESSENTIAL COVERAGE.—For purposes of this section, the term 'minimum essential coverage' has the meaning given such term by section 5000A(f).".

(b) ASSESSABLE PENALTIES.—

(1) Subparagraph (B) of section 6724(d)(1) of the Internal Revenue Code of 1986 (relating to definitions) is amended by striking "or" at the end of clause (xxii), by striking "and" at the end of clause (xxiii) and inserting "or", and by inserting after clause (xxiii) the following new clause:

"(xxiv) section 6055 (relating to returns relating to information regarding health insurance coverage), and".

(2) Paragraph (2) of section 6724(d) of such Code is amended by striking "or" at the end of subparagraph (EE), by striking the period at the end of subparagraph (FF) and inserting ", or" and by inserting after subparagraph (FF) the following new subparagraph:

"(GG) section 6055(c) (relating to statements relating to information regarding health insurance coverage).".

(c) NOTIFICATION OF NONENROLLMENT.—Not later than June 30 of each year, the Secretary of the Treasury, acting through the Internal Revenue Service and in consultation with the Secretary of Health and Human Services, shall send a notification to each individual who files an individual income tax return and who is not enrolled in minimum essential coverage (as defined in section 5000A of the Internal Revenue Code of 1986). Such notification shall contain information on the services available through the Exchange operating in the State in which such individual resides.

(d) CONFORMING AMENDMENT.—The table of subparts for part III of subchapter A of chapter 61 of such

1 Code is amended by inserting after the item relating to
2 subpart C the following new item:

"SUBPART D—INFORMATION REGARDING HEALTH INSURANCE COVERAGE".

3 (e) EFFECTIVE DATE.—The amendments made by
4 this section shall apply to calendar years beginning after
5 2013.

6 **PART II—EMPLOYER RESPONSIBILITIES**

7 **SEC. 1511. AUTOMATIC ENROLLMENT FOR EMPLOYEES OF**
8 **LARGE EMPLOYERS.**

9 The Fair Labor Standards Act of 1938 is amended
10 by inserting after section 18 (29 U.S.C. 218) the fol-
11 lowing:

12 **"SEC. 18A. AUTOMATIC ENROLLMENT FOR EMPLOYEES OF**
13 **LARGE EMPLOYERS.**

14 "In accordance with regulations promulgated by the
15 Secretary, an employer to which this Act applies that has
16 more than 200 full-time employees and that offers employ-
17 ees enrollment in 1 or more health benefits plans shall
18 automatically enroll new full-time employees in one of the
19 plans offered (subject to any waiting period authorized by
20 law) and to continue the enrollment of current employees
21 in a health benefits plan offered through the employer.
22 Any automatic enrollment program shall include adequate
23 notice and the opportunity for an employee to opt out of
24 any coverage the individual or employee were automati-
25 cally enrolled in. Nothing in this section shall be construed

to supersede any State law which establishes, implements, or continues in effect any standard or requirement relating to employers in connection with payroll except to the extent that such standard or requirement prevents an employer from instituting the automatic enrollment program under this section.''.

SEC. 1512. EMPLOYER REQUIREMENT TO INFORM EMPLOYEES OF COVERAGE OPTIONS.

The Fair Labor Standards Act of 1938 is amended by inserting after section 18A (as added by section 1513) the following:

''SEC. 18B. NOTICE TO EMPLOYEES.

''(a) IN GENERAL.—In accordance with regulations promulgated by the Secretary, an employer to which this Act applies, shall provide to each employee at the time of hiring (or with respect to current employees, not later than March 1, 2013), written notice—

''(1) informing the employee of the existence of an Exchange, including a description of the services provided by such Exchange, and the manner in which the employee may contact the Exchange to request assistance;

''(2) if the employer plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs, that the employee

may be eligible for a premium tax credit under section 36B of the Internal Revenue Code of 1986 and a cost sharing reduction under section 1402 of the Patient Protection and Affordable Care Act if the employee purchases a qualified health plan through the Exchange; and

"(3) if the employee purchases a qualified health plan through the Exchange, the employee will lose the employer contribution (if any) to any health benefits plan offered by the employer and that all or a portion of such contribution may be excludable from income for Federal income tax purposes.

"(b) EFFECTIVE DATE.—Subsection (a) shall take effect with respect to employers in a State beginning on March 1, 2013.".

SEC. 1513. SHARED RESPONSIBILITY FOR EMPLOYERS.

(a) IN GENERAL.—Chapter 43 of the Internal Revenue Code of 1986 is amended by adding at the end the following:

"SEC. 4980H. SHARED RESPONSIBILITY FOR EMPLOYERS REGARDING HEALTH COVERAGE.

"(a) LARGE EMPLOYERS NOT OFFERING HEALTH COVERAGE.—If—

"(1) any applicable large employer fails to offer to its full-time employees (and their dependents) the

1 opportunity to enroll in minimum essential coverage
2 under an eligible employer-sponsored plan (as de-
3 fined in section 5000A(f)(2)) for any month, and
4 ''(2) at least one full-time employee of the ap-
5 plicable large employer has been certified to the em-
6 ployer under section 1411 of the Patient Protection
7 and Affordable Care Act as having enrolled for such
8 month in a qualified health plan with respect to
9 which an applicable premium tax credit or cost-shar-
10 ing reduction is allowed or paid with respect to the
11 employee,
12 then there is hereby imposed on the employer an assess-
13 able payment equal to the product of the applicable pay-
14 ment amount and the number of individuals employed by
15 the employer as full-time employees during such month.
16 ''(b) LARGE EMPLOYERS WITH WAITING PERIODS
17 EXCEEDING 30 DAYS.—
18 ''(1) IN GENERAL.—In the case of any applica-
19 ble large employer which requires an extended wait-
20 ing period to enroll in any minimum essential cov-
21 erage under an employer-sponsored plan (as defined
22 in section 5000A(f)(2)), there is hereby imposed on
23 the employer an assessable payment, in the amount
24 specified in paragraph (2), for each full-time em-

1 ployee of the employer to whom the extended waiting
2 period applies.
3 "(2) AMOUNT.—For purposes of paragraph (1),
4 the amount specified in this paragraph for a full-
5 time employee is—
6 "(A) in the case of an extended waiting pe-
7 riod which exceeds 30 days but does not exceed
8 60 days, $400, and
9 "(B) in the case of an extended waiting pe-
10 riod which exceeds 60 days, $600.
11 "(3) EXTENDED WAITING PERIOD.—The term
12 'extended waiting period' means any waiting period
13 (as defined in section 2701(b)(4) of the Public
14 Health Service Act) which exceeds 30 days.
15 "(c) LARGE EMPLOYERS OFFERING COVERAGE
16 WITH EMPLOYEES WHO QUALIFY FOR PREMIUM TAX
17 CREDITS OR COST-SHARING REDUCTIONS.—
18 "(1) IN GENERAL.—If—
19 "(A) an applicable large employer offers to
20 its full-time employees (and their dependents)
21 the opportunity to enroll in minimum essential
22 coverage under an eligible employer-sponsored
23 plan (as defined in section 5000A(f)(2)) for any
24 month, and

"(B) 1 or more full-time employees of the applicable large employer has been certified to the employer under section 1411 of the Patient Protection and Affordable Care Act as having enrolled for such month in a qualified health plan with respect to which an applicable premium tax credit or cost-sharing reduction is allowed or paid with respect to the employee,

then there is hereby imposed on the employer an assessable payment equal to the product of the number of full-time employees of the applicable large employer described in subparagraph (B) for such month and 400 percent of the applicable payment amount.

"(2) OVERALL LIMITATION.—The aggregate amount of tax determined under paragraph (1) with respect to all employees of an applicable large employer for any month shall not exceed the product of the applicable payment amount and the number of individuals employed by the employer as full-time employees during such month.

"(d) DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

"(1) APPLICABLE PAYMENT AMOUNT.—The term 'applicable payment amount' means, with respect to any month, 1/12 of $750.

"(2) APPLICABLE LARGE EMPLOYER.—

"(A) IN GENERAL.—The term 'applicable large employer' means, with respect to a calendar year, an employer who employed an average of at least 50 full-time employees on business days during the preceding calendar year.

"(B) EXEMPTION FOR CERTAIN EMPLOYERS.—

"(i) IN GENERAL.—An employer shall not be considered to employ more than 50 full-time employees if—

"(I) the employer's workforce exceeds 50 full-time employees for 120 days or fewer during the calendar year, and

"(II) the employees in excess of 50 employed during such 120-day period were seasonal workers.

"(ii) DEFINITION OF SEASONAL WORKERS.—The term 'seasonal worker' means a worker who performs labor or services on a seasonal basis as defined by

the Secretary of Labor, including workers covered by section 500.20(s)(1) of title 29, Code of Federal Regulations and retail workers employed exclusively during holiday seasons.

"(C) RULES FOR DETERMINING EMPLOYER SIZE.—For purposes of this paragraph—

"(i) APPLICATION OF AGGREGATION RULE FOR EMPLOYERS.—All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as 1 employer.

"(ii) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is an applicable large employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

"(iii) PREDECESSORS.—Any reference in this subsection to an employer shall in-

1 clude a reference to any predecessor of
2 such employer.
3 "(3) APPLICABLE PREMIUM TAX CREDIT AND
4 COST-SHARING REDUCTION.—The term 'applicable
5 premium tax credit and cost-sharing reduction'
6 means—
7 "(A) any premium tax credit allowed under
8 section 36B,
9 "(B) any cost-sharing reduction under sec-
10 tion 1402 of the Patient Protection and Afford-
11 able Care Act, and
12 "(C) any advance payment of such credit
13 or reduction under section 1412 of such Act.
14 "(4) FULL-TIME EMPLOYEE.—
15 "(A) IN GENERAL.—The term 'full-time
16 employee' means an employee who is employed
17 on average at least 30 hours of service per
18 week.
19 "(B) HOURS OF SERVICE.—The Secretary,
20 in consultation with the Secretary of Labor,
21 shall prescribe such regulations, rules, and
22 guidance as may be necessary to determine the
23 hours of service of an employee, including rules
24 for the application of this paragraph to employ-

ees who are not compensated on an hourly basis.

"(5) INFLATION ADJUSTMENT.—

"(A) IN GENERAL.—In the case of any calendar year after 2014, each of the dollar amounts in subsection (b)(2) and (d)(1) shall be increased by an amount equal to the product of—

"(i) such dollar amount, and

"(ii) the premium adjustment percentage (as defined in section 1302(c)(4) of the Patient Protection and Affordable Care Act) for the calendar year.

"(B) ROUNDING.—If the amount of any increase under subparagraph (A) is not a multiple of $10, such increase shall be rounded to the next lowest multiple of $10.

"(6) OTHER DEFINITIONS.—Any term used in this section which is also used in the Patient Protection and Affordable Care Act shall have the same meaning as when used in such Act.

"(7) TAX NONDEDUCTIBLE.—For denial of deduction for the tax imposed by this section, see section 275(a)(6).

"(e) ADMINISTRATION AND PROCEDURE.—

"(1) IN GENERAL.—Any assessable payment provided by this section shall be paid upon notice and demand by the Secretary, and shall be assessed and collected in the same manner as an assessable penalty under subchapter B of chapter 68.

"(2) TIME FOR PAYMENT.—The Secretary may provide for the payment of any assessable payment provided by this section on an annual, monthly, or other periodic basis as the Secretary may prescribe.

"(3) COORDINATION WITH CREDITS, ETC..—The Secretary shall prescribe rules, regulations, or guidance for the repayment of any assessable payment (including interest) if such payment is based on the allowance or payment of an applicable premium tax credit or cost-sharing reduction with respect to an employee, such allowance or payment is subsequently disallowed, and the assessable payment would not have been required to be made but for such allowance or payment.".

(b) CLERICAL AMENDMENT.—The table of sections for chapter 43 of such Code is amended by adding at the end the following new item:

"Sec. 4980H. Shared responsibility for employers regarding health coverage.".

(c) STUDY AND REPORT OF EFFECT OF TAX ON WORKERS' WAGES.—

(1) IN GENERAL.—The Secretary of Labor shall conduct a study to determine whether employees' wages are reduced by reason of the application of the assessable payments under section 4980H of the Internal Revenue Code of 1986 (as added by the amendments made by this section). The Secretary shall make such determination on the basis of the National Compensation Survey published by the Bureau of Labor Statistics.

(2) REPORT.—The Secretary shall report the results of the study under paragraph (1) to the Committee on Ways and Means of the House of Representatives and to the Committee on Finance of the Senate.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to months beginning after December 31, 2013.

SEC. 1514. REPORTING OF EMPLOYER HEALTH INSURANCE COVERAGE.

(a) IN GENERAL.—Subpart D of part III of subchapter A of chapter 61 of the Internal Revenue Code of 1986, as added by section 1502, is amended by inserting after section 6055 the following new section:

"SEC. 6056. LARGE EMPLOYERS REQUIRED TO REPORT ON HEALTH INSURANCE COVERAGE.

"(a) IN GENERAL.—Every applicable large employer required to meet the requirements of section 4980H with respect to its full-time employees during a calendar year shall, at such time as the Secretary may prescribe, make a return described in subsection (b).

"(b) FORM AND MANNER OF RETURN.—A return is described in this subsection if such return—

"(1) is in such form as the Secretary may prescribe, and

"(2) contains—

"(A) the name, date, and employer identification number of the employer,

"(B) a certification as to whether the employer offers to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan (as defined in section 5000A(f)(2)),

"(C) if the employer certifies that the employer did offer to its full-time employees (and their dependents) the opportunity to so enroll—

"(i) the length of any waiting period (as defined in section 2701(b)(4) of the

1 Public Health Service Act) with respect to
2 such coverage,
3 "(ii) the months during the calendar
4 year for which coverage under the plan was
5 available,
6 "(iii) the monthly premium for the
7 lowest cost option in each of the enroll-
8 ment categories under the plan, and
9 "(iv) the applicable large employer's
10 share of the total allowed costs of benefits
11 provided under the plan,
12 "(D) the number of full-time employees for
13 each month during the calendar year,
14 "(E) the name, address, and TIN of each
15 full-time employee during the calendar year and
16 the months (if any) during which such employee
17 (and any dependents) were covered under any
18 such health benefits plans, and
19 "(F) such other information as the Sec-
20 retary may require.
21 "(c) STATEMENTS TO BE FURNISHED TO INDIVID-
22 UALS WITH RESPECT TO WHOM INFORMATION IS RE-
23 PORTED.—
24 "(1) IN GENERAL.—Every person required to
25 make a return under subsection (a) shall furnish to

each full-time employee whose name is required to be set forth in such return under subsection (b)(2)(E) a written statement showing—

"(A) the name and address of the person required to make such return and the phone number of the information contact for such person, and

"(B) the information required to be shown on the return with respect to such individual.

"(2) TIME FOR FURNISHING STATEMENTS.—The written statement required under paragraph (1) shall be furnished on or before January 31 of the year following the calendar year for which the return under subsection (a) was required to be made.

"(d) COORDINATION WITH OTHER REQUIREMENTS.—To the maximum extent feasible, the Secretary may provide that—

"(1) any return or statement required to be provided under this section may be provided as part of any return or statement required under section 6051 or 6055, and

"(2) in the case of an applicable large employer offering health insurance coverage of a health insurance issuer, the employer may enter into an agreement with the issuer to include information required

under this section with the return and statement required to be provided by the issuer under section 6055.

"(e) COVERAGE PROVIDED BY GOVERNMENTAL UNITS.—In the case of any applicable large employer which is a governmental unit or any agency or instrumentality thereof, the person appropriately designated for purposes of this section shall make the returns and statements required by this section.

"(f) DEFINITIONS.—For purposes of this section, any term used in this section which is also used in section 4980H shall have the meaning given such term by section 4980H.".

(b) ASSESSABLE PENALTIES.—

(1) Subparagraph (B) of section 6724(d)(1) of the Internal Revenue Code of 1986 (relating to definitions), as amended by section 1502, is amended by striking "or" at the end of clause (xxiii), by striking "and" at the end of clause (xxiv) and inserting "or", and by inserting after clause (xxiv) the following new clause:

"(xxv) section 6056 (relating to returns relating to large employers required to report on health insurance coverage), and".

(2) Paragraph (2) of section 6724(d) of such Code, as so amended, is amended by striking ''or'' at the end of subparagraph (FF), by striking the period at the end of subparagraph (GG) and inserting '', or'' and by inserting after subparagraph (GG) the following new subparagraph:

''(HH) section 6056(c) (relating to statements relating to large employers required to report on health insurance coverage).''.

(c) CONFORMING AMENDMENT.—The table of sections for subpart D of part III of subchapter A of chapter 61 of such Code, as added by section 1502, is amended by adding at the end the following new item:

''Sec. 6056. Large employers required to report on health insurance coverage.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to periods beginning after December 31, 2013.

SEC. 1515. OFFERING OF EXCHANGE-PARTICIPATING QUALIFIED HEALTH PLANS THROUGH CAFETERIA PLANS.

(a) IN GENERAL.—Subsection (f) of section 125 of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:

''(3) CERTAIN EXCHANGE-PARTICIPATING QUALIFIED HEALTH PLANS NOT QUALIFIED.—

"(A) IN GENERAL.—The term 'qualified benefit' shall not include any qualified health plan (as defined in section 1301(a) of the Patient Protection and Affordable Care Act) offered through an Exchange established under section 1311 of such Act.

"(B) EXCEPTION FOR EXCHANGE-ELIGIBLE EMPLOYERS.—Subparagraph (A) shall not apply with respect to any employee if such employee's employer is a qualified employer (as defined in section 1312(f)(2) of the Patient Protection and Affordable Care Act) offering the employee the opportunity to enroll through such an Exchange in a qualified health plan in a group market.".

(b) CONFORMING AMENDMENTS.—Subsection (f) of section 125 of such Code is amended—

(1) by striking "For purposes of this section, the term" and inserting "For purposes of this section—

"(1) IN GENERAL.—The term", and

(2) by striking "Such term shall not include" and inserting the following:

"(2) LONG-TERM CARE INSURANCE NOT QUALIFIED.—The term 'qualified benefit' shall not include".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2013.

Subtitle G—Miscellaneous Provisions

SEC. 1551. DEFINITIONS.

Unless specifically provided for otherwise, the definitions contained in section 2791 of the Public Health Service Act (42 U.S.C. 300gg-91) shall apply with respect to this title.

SEC. 1552. TRANSPARENCY IN GOVERNMENT.

Not later than 30 days after the date of enactment of this Act, the Secretary of Health and Human Services shall publish on the Internet website of the Department of Health and Human Services, a list of all of the authorities provided to the Secretary under this Act (and the amendments made by this Act).

SEC. 1553. PROHIBITION AGAINST DISCRIMINATION ON ASSISTED SUICIDE.

(a) IN GENERAL.—The Federal Government, and any State or local government or health care provider that receives Federal financial assistance under this Act (or

1 under an amendment made by this Act) or any health plan
2 created under this Act (or under an amendment made by
3 this Act), may not subject an individual or institutional
4 health care entity to discrimination on the basis that the
5 entity does not provide any health care item or service fur-
6 nished for the purpose of causing, or for the purpose of
7 assisting in causing, the death of any individual, such as
8 by assisted suicide, euthanasia, or mercy killing.

9 (b) DEFINITION.—In this section, the term ''health
10 care entity'' includes an individual physician or other
11 health care professional, a hospital, a provider-sponsored
12 organization, a health maintenance organization, a health
13 insurance plan, or any other kind of health care facility,
14 organization, or plan.

15 (c) CONSTRUCTION AND TREATMENT OF CERTAIN
16 SERVICES.—Nothing in subsection (a) shall be construed
17 to apply to, or to affect, any limitation relating to—

18 (1) the withholding or withdrawing of medical
19 treatment or medical care;

20 (2) the withholding or withdrawing of nutrition
21 or hydration;

22 (3) abortion; or

23 (4) the use of an item, good, benefit, or service
24 furnished for the purpose of alleviating pain or dis-
25 comfort, even if such use may increase the risk of

1 death, so long as such item, good, benefit, or service
2 is not also furnished for the purpose of causing, or
3 the purpose of assisting in causing, death, for any
4 reason.

5 (d) ADMINISTRATION.—The Office for Civil Rights of
6 the Department of Health and Human Services is des-
7 ignated to receive complaints of discrimination based on
8 this section.

9 **SEC. 1554. ACCESS TO THERAPIES.**

10 Notwithstanding any other provision of this Act, the
11 Secretary of Health and Human Services shall not pro-
12 mulgate any regulation that—

13 (1) creates any unreasonable barriers to the
14 ability of individuals to obtain appropriate medical
15 care;

16 (2) impedes timely access to health care serv-
17 ices;

18 (3) interferes with communications regarding a
19 full range of treatment options between the patient
20 and the provider;

21 (4) restricts the ability of health care providers
22 to provide full disclosure of all relevant information
23 to patients making health care decisions;

(5) violates the principles of informed consent and the ethical standards of health care professionals; or

(6) limits the availability of health care treatment for the full duration of a patient's medical needs.

SEC. 1555. FREEDOM NOT TO PARTICIPATE IN FEDERAL HEALTH INSURANCE PROGRAMS.

No individual, company, business, nonprofit entity, or health insurance issuer offering group or individual health insurance coverage shall be required to participate in any Federal health insurance program created under this Act (or any amendments made by this Act), or in any Federal health insurance program expanded by this Act (or any such amendments), and there shall be no penalty or fine imposed upon any such issuer for choosing not to participate in such programs.

SEC. 1556. EQUITY FOR CERTAIN ELIGIBLE SURVIVORS.

(a) REBUTTABLE PRESUMPTION.—Section 411(c)(4) of the Black Lung Benefits Act (30 U.S.C. 921(c)(4)) is amended by striking the last sentence.

(b) CONTINUATION OF BENEFITS.—Section 422(l) of the Black Lung Benefits Act (30 U.S.C. 932(l)) is amended by striking ", except with respect to a claim filed under

1 this part on or after the effective date of the Black Lung
2 Benefits Amendments of 1981''.

3 (c) EFFECTIVE DATE.—The amendments made by
4 this section shall apply with respect to claims filed under
5 part B or part C of the Black Lung Benefits Act (30
6 U.S.C. 921 et seq., 931 et seq.) after January 1, 2005,
7 that are pending on or after the date of enactment of this
8 Act.

9 **SEC. 1557. NONDISCRIMINATION.**

10 (a) IN GENERAL.—Except as otherwise provided for
11 in this title (or an amendment made by this title), an indi-
12 vidual shall not, on the ground prohibited under title VI
13 of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.),
14 title IX of the Education Amendments of 1972 (20 U.S.C.
15 1681 et seq.), the Age Discrimination Act of 1975 (42
16 U.S.C. 6101 et seq.), or section 504 of the Rehabilitation
17 Act of 1973 (29 U.S.C. 794), be excluded from participa-
18 tion in, be denied the benefits of, or be subjected to dis-
19 crimination under, any health program or activity, any
20 part of which is receiving Federal financial assistance, in-
21 cluding credits, subsidies, or contracts of insurance, or
22 under any program or activity that is administered by an
23 Executive Agency or any entity established under this title
24 (or amendments). The enforcement mechanisms provided
25 for and available under such title VI, title IX, section 504,

1 or such Age Discrimination Act shall apply for purposes
2 of violations of this subsection.

3 (b) CONTINUED APPLICATION OF LAWS.—Nothing in
4 this title (or an amendment made by this title) shall be
5 construed to invalidate or limit the rights, remedies, proce-
6 dures, or legal standards available to individuals aggrieved
7 under title VI of the Civil Rights Act of 1964 (42 U.S.C.
8 2000d et seq.), title VII of the Civil Rights Act of 1964
9 (42 U.S.C. 2000e et seq.), title IX of the Education
10 Amendments of 1972 (20 U.S.C. 1681 et seq.), section
11 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794),
12 or the Age Discrimination Act of 1975 (42 U.S.C. 611
13 et seq.), or to supersede State laws that provide additional
14 protections against discrimination on any basis described
15 in subsection (a).

16 (c) REGULATIONS.—The Secretary may promulgate
17 regulations to implement this section.

18 **SEC. 1558. PROTECTIONS FOR EMPLOYEES.**

19 The Fair Labor Standards Act of 1938 is amended
20 by inserting after section 18B (as added by section 1512)
21 the following:

22 **"SEC. 18C. PROTECTIONS FOR EMPLOYEES.**

23 "(a) PROHIBITION.—No employer shall discharge or
24 in any manner discriminate against any employee with re-
25 spect to his or her compensation, terms, conditions, or

other privileges of employment because the employee (or an individual acting at the request of the employee) has—

"(1) received a credit under section 36B of the Internal Revenue Code of 1986 or a subsidy under section 1402 of this Act;

"(2) provided, caused to be provided, or is about to provide or cause to be provided to the employer, the Federal Government, or the attorney general of a State information relating to any violation of, or any act or omission the employee reasonably believes to be a violation of, any provision of this title (or an amendment made by this title);

"(3) testified or is about to testify in a proceeding concerning such violation;

"(4) assisted or participated, or is about to assist or participate, in such a proceeding; or

"(5) objected to, or refused to participate in, any activity, policy, practice, or assigned task that the employee (or other such person) reasonably believed to be in violation of any provision of this title (or amendment), or any order, rule, regulation, standard, or ban under this title (or amendment).

"(b) COMPLAINT PROCEDURE.—

"(1) IN GENERAL.—An employee who believes that he or she has been discharged or otherwise dis-

criminated against by any employer in violation of this section may seek relief in accordance with the procedures, notifications, burdens of proof, remedies, and statutes of limitation set forth in section 2087(b) of title 15, United States Code.

"(2) NO LIMITATION ON RIGHTS.—Nothing in this section shall be deemed to diminish the rights, privileges, or remedies of any employee under any Federal or State law or under any collective bargaining agreement. The rights and remedies in this section may not be waived by any agreement, policy, form, or condition of employment.".

SEC. 1559. OVERSIGHT.

The Inspector General of the Department of Health and Human Services shall have oversight authority with respect to the administration and implementation of this title as it relates to such Department.

SEC. 1560. RULES OF CONSTRUCTION.

(a) NO EFFECT ON ANTITRUST LAWS.—Nothing in this title (or an amendment made by this title) shall be construed to modify, impair, or supersede the operation of any of the antitrust laws. For the purposes of this section, the term "antitrust laws" has the meaning given such term in subsection (a) of the first section of the Clayton Act, except that such term includes section 5 of the

1 Federal Trade Commission Act to the extent that such
2 section 5 applies to unfair methods of competition.

3 (b) RULE OF CONSTRUCTION REGARDING HAWAII'S
4 PREPAID HEALTH CARE ACT.—Nothing in this title (or
5 an amendment made by this title) shall be construed to
6 modify or limit the application of the exemption for Ha-
7 waii's Prepaid Health Care Act (Haw. Rev. Stat. §§ 393-
8 1 et seq.) as provided for under section 514(b)(5) of the
9 Employee Retirement Income Security Act of 1974 (29
10 U.S.C. 1144(b)(5)).

11 (c) STUDENT HEALTH INSURANCE PLANS.—Nothing
12 in this title (or an amendment made by this title) shall
13 be construed to prohibit an institution of higher education
14 (as such term is defined for purposes of the Higher Edu-
15 cation Act of 1965) from offering a student health insur-
16 ance plan, to the extent that such requirement is otherwise
17 permitted under applicable Federal, State or local law.

18 (d) NO EFFECT ON EXISTING REQUIREMENTS.—
19 Nothing in this title (or an amendment made by this title,
20 unless specified by direct statutory reference) shall be con-
21 strued to modify any existing Federal requirement con-
22 cerning the State agency responsible for determining eligi-
23 bility for programs identified in section 1413.

SEC. 1561. HEALTH INFORMATION TECHNOLOGY ENROLLMENT STANDARDS AND PROTOCOLS.

Title XXX of the Public Health Service Act (42 U.S.C. 300jj et seq.) is amended by adding at the end the following:

"Subtitle C—Other Provisions

"SEC. 3021. HEALTH INFORMATION TECHNOLOGY ENROLLMENT STANDARDS AND PROTOCOLS.

"(a) IN GENERAL.—

"(1) STANDARDS AND PROTOCOLS.—Not later than 180 days after the date of enactment of this title, the Secretary, in consultation with the HIT Policy Committee and the HIT Standards Committee, shall develop interoperable and secure standards and protocols that facilitate enrollment of individuals in Federal and State health and human services programs, as determined by the Secretary.

"(2) METHODS.—The Secretary shall facilitate enrollment in such programs through methods determined appropriate by the Secretary, which shall include providing individuals and third parties authorized by such individuals and their designees notification of eligibility and verification of eligibility required under such programs.

1 "(b) CONTENT.—The standards and protocols for
2 electronic enrollment in the Federal and State programs
3 described in subsection (a) shall allow for the following:
4 "(1) Electronic matching against existing Fed-
5 eral and State data, including vital records, employ-
6 ment history, enrollment systems, tax records, and
7 other data determined appropriate by the Secretary
8 to serve as evidence of eligibility and in lieu of
9 paper-based documentation.
10 "(2) Simplification and submission of electronic
11 documentation, digitization of documents, and sys-
12 tems verification of eligibility.
13 "(3) Reuse of stored eligibility information (in-
14 cluding documentation) to assist with retention of el-
15 igible individuals.
16 "(4) Capability for individuals to apply, recer-
17 tify and manage their eligibility information online,
18 including at home, at points of service, and other
19 community-based locations.
20 "(5) Ability to expand the enrollment system to
21 integrate new programs, rules, and functionalities, to
22 operate at increased volume, and to apply stream-
23 lined verification and eligibility processes to other
24 Federal and State programs, as appropriate.

1 "(6) Notification of eligibility, recertification,
2 and other needed communication regarding eligi-
3 bility, which may include communication via email
4 and cellular phones.
5 "(7) Other functionalities necessary to provide
6 eligibles with streamlined enrollment process.
7 "(c) APPROVAL AND NOTIFICATION.—With respect
8 to any standard or protocol developed under subsection (a)
9 that has been approved by the HIT Policy Committee and
10 the HIT Standards Committee, the Secretary—
11 "(1) shall notify States of such standards or
12 protocols; and
13 "(2) may require, as a condition of receiving
14 Federal funds for the health information technology
15 investments, that States or other entities incorporate
16 such standards and protocols into such investments.
17 "(d) GRANTS FOR IMPLEMENTATION OF APPRO-
18 PRIATE ENROLLMENT HIT.—
19 "(1) IN GENERAL.—The Secretary shall award
20 grant to eligible entities to develop new, and adapt
21 existing, technology systems to implement the HIT
22 enrollment standards and protocols developed under
23 subsection (a) (referred to in this subsection as 'ap-
24 propriate HIT technology').

1 "(2) ELIGIBLE ENTITIES.—To be eligible for a
2 grant under this subsection, an entity shall—
3 "(A) be a State, political subdivision of a
4 State, or a local governmental entity; and
5 "(B) submit to the Secretary an applica-
6 tion at such time, in such manner, and con-
7 taining—
8 "(i) a plan to adopt and implement
9 appropriate enrollment technology that in-
10 cludes—
11 "(I) proposed reduction in main-
12 tenance costs of technology systems;
13 "(II) elimination or updating of
14 legacy systems; and
15 "(III) demonstrated collaboration
16 with other entities that may receive a
17 grant under this section that are lo-
18 cated in the same State, political sub-
19 division, or locality;
20 "(ii) an assurance that the entity will
21 share such appropriate enrollment tech-
22 nology in accordance with paragraph (4);
23 and
24 "(iii) such other information as the
25 Secretary may require.

"(3) SHARING.—

"(A) IN GENERAL.—The Secretary shall ensure that appropriate enrollment HIT adopted under grants under this subsection is made available to other qualified State, qualified political subdivisions of a State, or other appropriate qualified entities (as described in subparagraph (B)) at no cost.

"(B) QUALIFIED ENTITIES.—The Secretary shall determine what entities are qualified to receive enrollment HIT under subparagraph (A), taking into consideration the recommendations of the HIT Policy Committee and the HIT Standards Committee.".

SEC. 1562. CONFORMING AMENDMENTS.

(a) APPLICABILITY.—Section 2735 of the Public Health Service Act (42 U.S.C. 300gg-21), as so redesignated by section 1001(4), is amended—

(1) by striking subsection (a);

(2) in subsection (b)—

(A) in paragraph (1), by striking "1 through 3" and inserting "1 and 2"; and

(B) in paragraph (2)—

(i) in subparagraph (A), by striking "subparagraph (D)" and inserting "subparagraph (D) or (E)";

(ii) by striking "1 through 3" and inserting "1 and 2"; and

(iii) by adding at the end the following:

"(E) ELECTION NOT APPLICABLE.—The election described in subparagraph (A) shall not be available with respect to the provisions of subpart 1.";

(3) in subsection (c), by striking "1 through 3 shall not apply to any group" and inserting "1 and 2 shall not apply to any individual coverage or any group"; and

(4) in subsection (d)—

(A) in paragraph (1), by striking "1 through 3 shall not apply to any group" and inserting "1 and 2 shall not apply to any individual coverage or any group";

(B) in paragraph (2)—

(i) in the matter preceding subparagraph (A), by striking "1 through 3 shall not apply to any group" and inserting "1

and 2 shall not apply to any individual coverage or any group''; and

(ii) in subparagraph (C), by inserting ''or, with respect to individual coverage, under any health insurance coverage maintained by the same health insurance issuer''; and

(C) in paragraph (3), by striking ''any group'' and inserting ''any individual coverage or any group''.

(b) DEFINITIONS.—Section 2791(d) of the Public Health Service Act (42 U.S.C. 300gg-91(d)) is amended by adding at the end the following:

''(20) QUALIFIED HEALTH PLAN.—The term 'qualified health plan' has the meaning given such term in section 1301(a) of the Patient Protection and Affordable Care Act.

''(21) EXCHANGE.—The term 'Exchange' means an American Health Benefit Exchange established under section 1311 of the Patient Protection and Affordable Care Act.''.

(c) TECHNICAL AND CONFORMING AMENDMENTS.—Title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.) is amended—

1 (1) in section 2704 (42 U.S.C. 300gg), as so
2 redesignated by section 1201(2)—
3 (A) in subsection (c)—
4 (i) in paragraph (2), by striking
5 ''group health plan'' each place that such
6 term appears and inserting ''group or indi-
7 vidual health plan''; and
8 (ii) in paragraph (3)—
9 (I) by striking ''group health in-
10 surance'' each place that such term
11 appears and inserting ''group or indi-
12 vidual health insurance''; and
13 (II) in subparagraph (D), by
14 striking ''small or large'' and insert-
15 ing ''individual or group'';
16 (B) in subsection (d), by striking ''group
17 health insurance'' each place that such term ap-
18 pears and inserting ''group or individual health
19 insurance''; and
20 (C) in subsection (e)(1)(A), by striking
21 ''group health insurance'' and inserting ''group
22 or individual health insurance'';
23 (2) by striking the second heading for subpart
24 2 of part A (relating to other requirements);

(3) in section 2725 (42 U.S.C. 300gg-4), as so redesignated by section 1001(2)—

(A) in subsection (a), by striking ''health insurance issuer offering group health insurance coverage'' and inserting ''health insurance issuer offering group or individual health insurance coverage'';

(B) in subsection (b)—

(i) by striking ''health insurance issuer offering group health insurance coverage in connection with a group health plan'' in the matter preceding paragraph (1) and inserting ''health insurance issuer offering group or individual health insurance coverage''; and

(ii) in paragraph (1), by striking ''plan'' and inserting ''plan or coverage'';

(C) in subsection (c)—

(i) in paragraph (2), by striking ''group health insurance coverage offered by a health insurance issuer'' and inserting ''health insurance issuer offering group or individual health insurance coverage''; and

(ii) in paragraph (3), by striking ''issuer'' and inserting ''health insurance issuer''; and

(D) in subsection (e), by striking ''health insurance issuer offering group health insurance coverage'' and inserting ''health insurance issuer offering group or individual health insurance coverage'';

(4) in section 2726 (42 U.S.C. 300gg-5), as so redesignated by section 1001(2)—

(A) in subsection (a), by striking ''(or health insurance coverage offered in connection with such a plan)'' each place that such term appears and inserting ''or a health insurance issuer offering group or individual health insurance coverage'';

(B) in subsection (b), by striking ''(or health insurance coverage offered in connection with such a plan)'' each place that such term appears and inserting ''or a health insurance issuer offering group or individual health insurance coverage''; and

(C) in subsection (c)—

(i) in paragraph (1), by striking ''(and group health insurance coverage offered in

connection with a group health plan)'' and inserting ''and a health insurance issuer offering group or individual health insurance coverage'';

(ii) in paragraph (2), by striking ''(or health insurance coverage offered in connection with such a plan)'' each place that such term appears and inserting ''or a health insurance issuer offering group or individual health insurance coverage'';

(5) in section 2727 (42 U.S.C. 300gg-6), as so redesignated by section 1001(2), by striking ''health insurance issuers providing health insurance coverage in connection with group health plans'' and inserting ''and health insurance issuers offering group or individual health insurance coverage'';

(6) in section 2728 (42 U.S.C. 300gg-7), as so redesignated by section 1001(2)—

(A) in subsection (a), by striking ''health insurance coverage offered in connection with such plan'' and inserting ''individual health insurance coverage'';

(B) in subsection (b)—

(i) in paragraph (1), by striking ''or a health insurance issuer that provides

1 health insurance coverage in connection
2 with a group health plan'' and inserting
3 ''or a health insurance issuer that offers
4 group or individual health insurance cov-
5 erage'';
6 (ii) in paragraph (2), by striking
7 ''health insurance coverage offered in con-
8 nection with the plan'' and inserting ''indi-
9 vidual health insurance coverage''; and
10 (iii) in paragraph (3), by striking
11 ''health insurance coverage offered by an
12 issuer in connection with such plan'' and
13 inserting ''individual health insurance cov-
14 erage'';
15 (C) in subsection (c), by striking ''health
16 insurance issuer providing health insurance cov-
17 erage in connection with a group health plan''
18 and inserting ''health insurance issuer that of-
19 fers group or individual health insurance cov-
20 erage''; and
21 (D) in subsection (e)(1), by striking
22 ''health insurance coverage offered in connec-
23 tion with such a plan'' and inserting ''individual
24 health insurance coverage'';
25 (7) by striking the heading for subpart 3;

(8) in section 2731 (42 U.S.C. 300gg-11), as so redesignated by section 1001(3)—

(A) by striking the section heading and all that follows through subsection (b);

(B) in subsection (c)—

(i) in paragraph (1)—

(I) in the matter preceding subparagraph (A), by striking ''small group'' and inserting ''group and individual''; and

(II) in subparagraph (B)—

(aa) in the matter preceding clause (i), by inserting ''and individuals'' after ''employers'';

(bb) in clause (i), by inserting ''or any additional individuals'' after ''additional groups''; and

(cc) in clause (ii), by striking ''without regard to the claims experience of those employers and their employees (and their dependents) or any health status-related factor relating to such'' and inserting ''and individuals

without regard to the claims experience of those individuals, employers and their employees (and their dependents) or any health status-related factor relating to such individuals''; and

(ii) in paragraph (2), by striking ''small group'' and inserting ''group or individual'';

(C) in subsection (d)—

(i) by striking ''small group'' each place that such appears and inserting ''group or individual''; and

(ii) in paragraph (1)(B)—

(I) by striking ''all employers'' and inserting ''all employers and individuals'';

(II) by striking ''those employers'' and inserting ''those individuals, employers''; and

(III) by striking ''such employees'' and inserting ''such individuals, employees'';

(D) by striking subsection (e);

(E) by striking subsection (f); and

(F) by transferring such section (as amended by this paragraph) to appear at the end of section 2702 (as added by section 1001(4));

(9) in section 2732 (42 U.S.C. 300gg-12), as so redesignated by section 1001(3)—

(A) by striking the section heading and all that follows through subsection (a);

(B) in subsection (b)—

(i) in the matter preceding paragraph (1), by striking ''group health plan in the small or large group market'' and inserting ''health insurance coverage offered in the group or individual market'';

(ii) in paragraph (1), by inserting '', or individual, as applicable,'' after ''plan sponsor'';

(iii) in paragraph (2), by inserting '', or individual, as applicable,'' after ''plan sponsor''; and

(iv) by striking paragraph (3) and inserting the following:

''(3) VIOLATION OF PARTICIPATION OR CONTRIBUTION RATES.—In the case of a group health plan, the plan sponsor has failed to comply with a

1 material plan provision relating to employer con-
2 tribution or group participation rules, pursuant to
3 applicable State law.'';
4 (C) in subsection (c)—
5 (i) in paragraph (1)—
6 (I) in the matter preceding sub-
7 paragraph (A), by striking ''group
8 health insurance coverage offered in
9 the small or large group market'' and
10 inserting ''group or individual health
11 insurance coverage'';
12 (II) in subparagraph (A), by in-
13 serting ''or individual, as applicable,''
14 after ''plan sponsor'';
15 (III) in subparagraph (B)—
16 (aa) by inserting ''or indi-
17 vidual, as applicable,'' after ''plan
18 sponsor''; and
19 (bb) by inserting ''or indi-
20 vidual health insurance cov-
21 erage''; and
22 (IV) in subparagraph (C), by in-
23 serting ''or individuals, as applicable,''
24 after ''those sponsors''; and
25 (ii) in paragraph (2)(A)—

(I) in the matter preceding clause (i), by striking ''small group market or the large group market, or both markets,'' and inserting ''individual or group market, or all markets,''; and

(II) in clause (i), by inserting ''or individual, as applicable,'' after ''plan sponsor''; and

(D) by transferring such section (as amended by this paragraph) to appear at the end of section 2703 (as added by section 1001(4));

(10) in section 2733 (42 U.S.C. 300gg-13), as so redesignated by section 1001(4)—

(A) in subsection (a)—

(i) in the matter preceding paragraph (1), by striking ''small employer'' and inserting ''small employer or an individual'';

(ii) in paragraph (1), by inserting '', or individual, as applicable,'' after ''employer'' each place that such appears; and

(iii) in paragraph (2), by striking ''small employer'' and inserting ''employer, or individual, as applicable,'';

(B) in subsection (b)—

(i) in paragraph (1)—

(I) in the matter preceding subparagraph (A), by striking ''small employer'' and inserting ''employer, or individual, as applicable,'';

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

(III) by striking subparagraphs (B) and (C); and

(IV) in subparagraph (D)—

(aa) by inserting '', or individual, as applicable,'' after ''employer''; and

(bb) by redesignating such subparagraph as subparagraph (B);

(ii) in paragraph (2)—

(I) by striking ''small employers'' each place that such term appears and inserting ''employers, or individuals, as applicable,''; and

(II) by striking ''small employer'' and inserting ''employer, or individual, as applicable,''; and

(C) by redesignating such section (as amended by this paragraph) as section 2709 and transferring such section to appear after section 2708 (as added by section 1001(5));

(11) by redesignating subpart 4 as subpart 2;

(12) in section 2735 (42 U.S.C. 300gg-21), as so redesignated by section 1001(4)—

(A) by striking subsection (a);

(B) by striking ''subparts 1 through 3'' each place that such appears and inserting ''subpart 1'';

(C) by redesignating subsections (b) through (e) as subsections (a) through (d), respectively; and

(D) by redesignating such section (as amended by this paragraph) as section 2722;

(13) in section 2736 (42 U.S.C. 300gg-22), as so redesignated by section 1001(4)—

(A) in subsection (a)—

(i) in paragraph (1), by striking ''small or large group markets'' and inserting ''individual or group market''; and

(ii) in paragraph (2), by inserting ''or individual health insurance coverage'' after ''group health plans'';

(B) in subsection (b)(1)(B), by inserting ''individual health insurance coverage or'' after ''respect to''; and

(C) by redesignating such section (as amended by this paragraph) as section 2723;

(14) in section 2737(a)(1) (42 U.S.C. 300gg-23), as so redesignated by section 1001(4)—

(A) by inserting ''individual or'' before ''group health insurance''; and

(B) by redesignating such section(as amended by this paragraph) as section 2724;

(15) in section 2762 (42 U.S.C. 300gg-62)—

(A) in the section heading by inserting ''**AND APPLICATION**'' before the period; and

(B) by adding at the end the following:

''(c) APPLICATION OF PART A PROVISIONS.—

''(1) IN GENERAL.—The provisions of part A shall apply to health insurance issuers providing health insurance coverage in the individual market in a State as provided for in such part.

''(2) CLARIFICATION.—To the extent that any provision of this part conflicts with a provision of part A with respect to health insurance issuers providing health insurance coverage in the individual

1 market in a State, the provisions of such part A
2 shall apply.''; and
3 (16) in section 2791(e) (42 U.S.C. 300gg-
4 91(e))—
5 (A) in paragraph (2), by striking ''51'' and
6 inserting ''101''; and
7 (B) in paragraph (4)—
8 (i) by striking ''at least 2'' each place
9 that such appears and inserting ''at least
10 1''; and
11 (ii) by striking ''50'' and inserting
12 ''100''.
13 (d) APPLICATION.—Notwithstanding any other provi-
14 sion of the Patient Protection and Affordable Care Act,
15 nothing in such Act (or an amendment made by such Act)
16 shall be construed to—
17 (1) prohibit (or authorize the Secretary of
18 Health and Human Services to promulgate regula-
19 tions that prohibit) a group health plan or health in-
20 surance issuer from carrying out utilization manage-
21 ment techniques that are commonly used as of the
22 date of enactment of this Act; or
23 (2) restrict the application of the amendments
24 made by this subtitle.

1 (e) TECHNICAL AMENDMENT TO THE EMPLOYEE
2 RETIREMENT INCOME SECURITY ACT OF 1974.—Subpart
3 B of part 7 of subtitle A of title I of the Employee Retire-
4 ment Income Security Act of 1974 (29 U.S.C. 1181 et.
5 seq.) is amended, by adding at the end the following:

6 **"SEC. 715. ADDITIONAL MARKET REFORMS.**

7 "(a) GENERAL RULE.—Except as provided in sub-
8 section (b)—

9 "(1) the provisions of part A of title XXVII of
10 the Public Health Service Act (as amended by the
11 Patient Protection and Affordable Care Act) shall
12 apply to group health plans, and health insurance
13 issuers providing health insurance coverage in con-
14 nection with group health plans, as if included in
15 this subpart; and

16 "(2) to the extent that any provision of this
17 part conflicts with a provision of such part A with
18 respect to group health plans, or health insurance
19 issuers providing health insurance coverage in con-
20 nection with group health plans, the provisions of
21 such part A shall apply.

22 "(b) EXCEPTION.—Notwithstanding subsection (a),
23 the provisions of sections 2716 and 2718 of title XXVII
24 of the Public Health Service Act (as amended by the Pa-
25 tient Protection and Affordable Care Act) shall not apply

1 with respect to self-insured group health plans, and the
2 provisions of this part shall continue to apply to such
3 plans as if such sections of the Public Health Service Act
4 (as so amended) had not been enacted.''.

5 (f) TECHNICAL AMENDMENT TO THE INTERNAL
6 REVENUE CODE OF 1986.—Subchapter B of chapter 100
7 of the Internal Revenue Code of 1986 is amended by add-
8 ing at the end the following:

9 **''SEC. 9815. ADDITIONAL MARKET REFORMS.**

10 ''(a) GENERAL RULE.—Except as provided in sub-
11 section (b)—

12 ''(1) the provisions of part A of title XXVII of
13 the Public Health Service Act (as amended by the
14 Patient Protection and Affordable Care Act) shall
15 apply to group health plans, and health insurance
16 issuers providing health insurance coverage in con-
17 nection with group health plans, as if included in
18 this subchapter; and

19 ''(2) to the extent that any provision of this
20 subchapter conflicts with a provision of such part A
21 with respect to group health plans, or health insur-
22 ance issuers providing health insurance coverage in
23 connection with group health plans, the provisions of
24 such part A shall apply.

"(b) EXCEPTION.—Notwithstanding subsection (a), the provisions of sections 2716 and 2718 of title XXVII of the Public Health Service Act (as amended by the Patient Protection and Affordable Care Act) shall not apply with respect to self-insured group health plans, and the provisions of this subchapter shall continue to apply to such plans as if such sections of the Public Health Service Act (as so amended) had not been enacted.".

TITLE II—ROLE OF PUBLIC PROGRAMS

Subtitle A—Improved Access to Medicaid

SEC. 2001. MEDICAID COVERAGE FOR THE LOWEST INCOME POPULATIONS.

(a) COVERAGE FOR INDIVIDUALS WITH INCOME AT OR BELOW 133 PERCENT OF THE POVERTY LINE.—

(1) BEGINNING 2014.—Section 1902(a)(10)(A)(i) of the Social Security Act (42 U.S.C. 1396a) is amended—

(A) by striking "or" at the end of subclause (VI);

(B) by adding "or" at the end of subclause (VII); and

(C) by inserting after subclause (VII) the following:

"(VIII) beginning January 1, 2014, who are under 65 years of age, not pregnant, not entitled to, or enrolled for, benefits under part A of title XVIII, or enrolled for benefits under part B of title XVIII, and are not described in a previous subclause of this clause, and whose income (as determined under subsection (e)(14)) does not exceed 133 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved, subject to subsection (k);".

(2) PROVISION OF AT LEAST MINIMUM ESSENTIAL COVERAGE.—

(A) IN GENERAL.—Section 1902 of such Act (42 U.S.C. 1396a) is amended by inserting after subsection (j) the following:

"(k)(1) The medical assistance provided to an individual described in subclause (VIII) of subsection (a)(10)(A)(i) shall consist of benchmark coverage described in section 1937(b)(1) or benchmark equivalent coverage described in section 1937(b)(2). Such medical assistance shall be provided subject to the requirements of

1 section 1937, without regard to whether a State otherwise
2 has elected the option to provide medical assistance
3 through coverage under that section, unless an individual
4 described in subclause (VIII) of subsection (a)(10)(A)(i)
5 is also an individual for whom, under subparagraph (B)
6 of section 1937(a)(2), the State may not require enroll-
7 ment in benchmark coverage described in subsection
8 (b)(1) of section 1937 or benchmark equivalent coverage
9 described in subsection (b)(2) of that section.''.

10 (B) CONFORMING AMENDMENT.—Section
11 1903(i) of the Social Security Act, as amended
12 by section 6402(c), is amended—

13 (i) in paragraph (24), by striking ''or''
14 at the end;

15 (ii) in paragraph (25), by striking the
16 period and inserting ''; or''; and

17 (iii) by adding at the end the fol-
18 lowing:

19 ''(26) with respect to any amounts expended for
20 medical assistance for individuals described in sub-
21 clause (VIII) of subsection (a)(10)(A)(i) other than
22 medical assistance provided through benchmark cov-
23 erage described in section 1937(b)(1) or benchmark
24 equivalent coverage described in section
25 1937(b)(2).''.

(3) FEDERAL FUNDING FOR COST OF COVERING NEWLY ELIGIBLE INDIVIDUALS.—Section 1905 of the Social Security Act (42 U.S.C. 1396d), is amended—

(A) in subsection (b), in the first sentence, by inserting ''subsection (y) and'' before ''section 1933(d)''; and

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

''(y) INCREASED FMAP FOR MEDICAL ASSISTANCE FOR NEWLY ELIGIBLE MANDATORY INDIVIDUALS.—

''(1) AMOUNT OF INCREASE.—

''(A) 100 PERCENT FMAP.—During the period that begins on January 1, 2014, and ends on December 31, 2016, notwithstanding subsection (b), the Federal medical assistance percentage determined for a State that is one of the 50 States or the District of Columbia for each fiscal year occurring during that period with respect to amounts expended for medical assistance for newly eligible individuals described in subclause (VIII) of section 1902(a)(10)(A)(i) shall be equal to 100 percent.

''(B) 2017 AND 2018.—

"(i) IN GENERAL.—During the period that begins on January 1, 2017, and ends on December 31, 2018, notwithstanding subsection (b) and subject to subparagraph (D), the Federal medical assistance percentage determined for a State that is one of the 50 States or the District of Columbia for each fiscal year occurring during that period with respect to amounts expended for medical assistance for newly eligible individuals described in subclause (VIII) of section 1902(a)(10)(A)(i), shall be increased by the applicable percentage point increase specified in clause (ii) for the quarter and the State.

"(ii) APPLICABLE PERCENTAGE POINT INCREASE.—

"(I) IN GENERAL.—For purposes of clause (i), the applicable percentage point increase for a quarter is the following:

"For any fiscal year quarter occurring in the calendar year:	If the State is an expansion State, the applicable percentage point increase is:	If the State is not an expansion State, the applicable percentage point increase is:
2017	30.3	34.3
2018	31.3	33.3

1 "(II) EXPANSION STATE DE-
2 FINED.—For purposes of the table in
3 subclause (I), a State is an expansion
4 State if, on the date of the enactment
5 of the Patient Protection and Afford-
6 able Care Act, the State offers health
7 benefits coverage statewide to parents
8 and nonpregnant, childless adults
9 whose income is at least 100 percent
10 of the poverty line, that is not depend-
11 ent on access to employer coverage,
12 employer contribution, or employment
13 and is not limited to premium assist-
14 ance, hospital-only benefits, a high de-
15 ductible health plan, or alternative
16 benefits under a demonstration pro-
17 gram authorized under section 1938.
18 A State that offers health benefits
19 coverage to only parents or only non-
20 pregnant childless adults described in
21 the preceding sentence shall not be
22 considered to be an expansion State.
23 "(C) 2019 AND SUCCEEDING YEARS.—Be-
24 ginning January 1, 2019, notwithstanding sub-
25 section (b) but subject to subparagraph (D),

1 the Federal medical assistance percentage de-
2 termined for a State that is one of the 50
3 States or the District of Columbia for each fis-
4 cal year quarter occurring during that period
5 with respect to amounts expended for medical
6 assistance for newly eligible individuals de-
7 scribed in subclause (VIII) of section
8 1902(a)(10)(A)(i), shall be increased by 32.3
9 percentage points.

10 ''(D) LIMITATION.—The Federal medical
11 assistance percentage determined for a State
12 under subparagraph (B) or (C) shall in no case
13 be more than 95 percent.

14 ''(2) DEFINITIONS.—In this subsection:

15 ''(A) NEWLY ELIGIBLE.—The term 'newly
16 eligible' means, with respect to an individual de-
17 scribed in subclause (VIII) of section
18 1902(a)(10)(A)(i), an individual who is not
19 under 19 years of age (or such higher age as
20 the State may have elected) and who, on the
21 date of enactment of the Patient Protection and
22 Affordable Care Act, is not eligible under the
23 State plan or under a waiver of the plan for full
24 benefits or for benchmark coverage described in
25 subparagraph (A), (B), or (C) of section

1937(b)(1) or benchmark equivalent coverage described in section 1937(b)(2) that has an aggregate actuarial value that is at least actuarially equivalent to benchmark coverage described in subparagraph (A), (B), or (C) of section 1937(b)(1), or is eligible but not enrolled (or is on a waiting list) for such benefits or coverage through a waiver under the plan that has a capped or limited enrollment that is full.

"(B) FULL BENEFITS.—The term 'full benefits' means, with respect to an individual, medical assistance for all services covered under the State plan under this title that is not less in amount, duration, or scope, or is determined by the Secretary to be substantially equivalent, to the medical assistance available for an individual described in section 1902(a)(10)(A)(i).".

(4) STATE OPTIONS TO OFFER COVERAGE EARLIER AND PRESUMPTIVE ELIGIBILITY; CHILDREN REQUIRED TO HAVE COVERAGE FOR PARENTS TO BE ELIGIBLE.—

(A) IN GENERAL.—Subsection (k) of section 1902 of the Social Security Act (as added by paragraph (2)), is amended by inserting after paragraph (1) the following:

1 "(2) Beginning with the first day of any fiscal year
2 quarter that begins on or after January 1, 2011, and be-
3 fore January 1, 2014, a State may elect through a State
4 plan amendment to provide medical assistance to individ-
5 uals who would be described in subclause (VIII) of sub-
6 section (a)(10)(A)(i) if that subclause were effective before
7 January 1, 2014. A State may elect to phase-in the exten-
8 sion of eligibility for medical assistance to such individuals
9 based on income, so long as the State does not extend
10 such eligibility to individuals described in such subclause
11 with higher income before making individuals described in
12 such subclause with lower income eligible for medical as-
13 sistance.

14 "(3) If an individual described in subclause (VIII) of
15 subsection (a)(10)(A)(i) is the parent of a child who is
16 under 19 years of age (or such higher age as the State
17 may have elected) who is eligible for medical assistance
18 under the State plan or under a waiver of such plan
19 (under that subclause or under a State plan amendment
20 under paragraph (2), the individual may not be enrolled
21 under the State plan unless the individual's child is en-
22 rolled under the State plan or under a waiver of the plan
23 or is enrolled in other health insurance coverage. For pur-
24 poses of the preceding sentence, the term 'parent' includes

1 an individual treated as a caretaker relative for purposes
2 of carrying out section 1931.''.

3 (B) PRESUMPTIVE ELIGIBILITY.—Section
4 1920 of the Social Security Act (42 U.S.C.
5 1396r–1) is amended by adding at the end the
6 following:

7 ''(e) If the State has elected the option to provide
8 a presumptive eligibility period under this section or sec-
9 tion 1920A, the State may elect to provide a presumptive
10 eligibility period (as defined in subsection (b)(1)) for indi-
11 viduals who are eligible for medical assistance under
12 clause (i)(VIII) of subsection (a)(10)(A) or section 1931
13 in the same manner as the State provides for such a pe-
14 riod under this section or section 1920A, subject to such
15 guidance as the Secretary shall establish.''.

16 (5) CONFORMING AMENDMENTS.—

17 (A) Section 1902(a)(10) of such Act (42
18 U.S.C. 1396a(a)(10)) is amended in the matter
19 following subparagraph (G), by striking ''and
20 (XIV)'' and inserting ''(XIV)'' and by inserting
21 ''and (XV) the medical assistance made avail-
22 able to an individual described in subparagraph
23 (A)(i)(VIII) shall be limited to medical assist-
24 ance described in subsection (k)(1)'' before the
25 semicolon.

(B) Section 1902(l)(2)(C) of such Act (42 U.S.C. 1396a(l)(2)(C)) is amended by striking ''100'' and inserting ''133''.

(C) Section 1905(a) of such Act (42 U.S.C. 1396d(a)) is amended in the matter preceding paragraph (1)—

(i) by striking ''or'' at the end of clause (xii);

(ii) by inserting ''or'' at the end of clause (xiii); and

(iii) by inserting after clause (xiii) the following:

''(xiv) individuals described in section 1902(a)(10)(A)(i)(VIII),''.

(D) Section 1903(f)(4) of such Act (42 U.S.C. 1396b(f)(4)) is amended by inserting ''1902(a)(10)(A)(i)(VIII),'' after ''1902(a)(10)(A)(i)(VII),''.

(E) Section 1937(a)(1)(B) of such Act (42 U.S.C. 1396u–7(a)(1)(B)) is amended by inserting ''subclause (VIII) of section 1902(a)(10)(A)(i) or under'' after ''eligible under''.

1 (b) MAINTENANCE OF MEDICAID INCOME ELIGI-
2 BILITY.—Section 1902 of the Social Security Act (42
3 U.S.C. 1396a) is amended—
4 (1) in subsection (a)—
5 (A) by striking ''and'' at the end of para-
6 graph (72);
7 (B) by striking the period at the end of
8 paragraph (73) and inserting ''; and''; and
9 (C) by inserting after paragraph (73) the
10 following new paragraph:
11 ''(74) provide for maintenance of effort under
12 the State plan or under any waiver of the plan in
13 accordance with subsection (gg).''; and
14 (2) by adding at the end the following new sub-
15 section:
16 ''(gg) MAINTENANCE OF EFFORT.—
17 ''(1) GENERAL REQUIREMENT TO MAINTAIN
18 ELIGIBILITY STANDARDS UNTIL STATE EXCHANGE IS
19 FULLY OPERATIONAL.—Subject to the succeeding
20 paragraphs of this subsection, during the period that
21 begins on the date of enactment of the Patient Pro-
22 tection and Affordable Care Act and ends on the
23 date on which the Secretary determines that an Ex-
24 change established by the State under section 1311
25 of the Patient Protection and Affordable Care Act is

1 fully operational, as a condition for receiving any
2 Federal payments under section 1903(a) for cal-
3 endar quarters occurring during such period, a State
4 shall not have in effect eligibility standards, meth-
5 odologies, or procedures under the State plan under
6 this title or under any waiver of such plan that is
7 in effect during that period, that are more restrictive
8 than the eligibility standards, methodologies, or pro-
9 cedures, respectively, under the plan or waiver that
10 are in effect on the date of enactment of the Patient
11 Protection and Affordable Care Act.

12 "(2) CONTINUATION OF ELIGIBILITY STAND-
13 ARDS FOR CHILDREN UNTIL OCTOBER 1, 2019.—The
14 requirement under paragraph (1) shall continue to
15 apply to a State through September 30, 2019, with
16 respect to the eligibility standards, methodologies,
17 and procedures under the State plan under this title
18 or under any waiver of such plan that are applicable
19 to determining the eligibility for medical assistance
20 of any child who is under 19 years of age (or such
21 higher age as the State may have elected).

22 "(3) NONAPPLICATION.—During the period
23 that begins on January 1, 2011, and ends on De-
24 cember 31, 2013, the requirement under paragraph
25 (1) shall not apply to a State with respect to non-

1 pregnant, nondisabled adults who are eligible for
2 medical assistance under the State plan or under a
3 waiver of the plan at the option of the State and
4 whose income exceeds 133 percent of the poverty
5 line (as defined in section 2110(c)(5)) applicable to
6 a family of the size involved if, on or after December
7 31, 2010, the State certifies to the Secretary that,
8 with respect to the State fiscal year during which
9 the certification is made, the State has a budget def-
10 icit, or with respect to the succeeding State fiscal
11 year, the State is projected to have a budget deficit.
12 Upon submission of such a certification to the Sec-
13 retary, the requirement under paragraph (1) shall
14 not apply to the State with respect to any remaining
15 portion of the period described in the preceding sen-
16 tence.

17 "(4) DETERMINATION OF COMPLIANCE.—

18 "(A) STATES SHALL APPLY MODIFIED
19 GROSS INCOME.—A State's determination of in-
20 come in accordance with subsection (e)(14)
21 shall not be considered to be eligibility stand-
22 ards, methodologies, or procedures that are
23 more restrictive than the standards, methodolo-
24 gies, or procedures in effect under the State
25 plan or under a waiver of the plan on the date

of enactment of the Patient Protection and Affordable Care Act for purposes of determining compliance with the requirements of paragraph (1), (2), or (3).

"(B) STATES MAY EXPAND ELIGIBILITY OR MOVE WAIVERED POPULATIONS INTO COVERAGE UNDER THE STATE PLAN.—With respect to any period applicable under paragraph (1), (2), or (3), a State that applies eligibility standards, methodologies, or procedures under the State plan under this title or under any waiver of the plan that are less restrictive than the eligibility standards, methodologies, or procedures, applied under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act, or that makes individuals who, on such date of enactment, are eligible for medical assistance under a waiver of the State plan, after such date of enactment eligible for medical assistance through a State plan amendment with an income eligibility level that is not less than the income eligibility level that applied under the waiver, or as a result of the application of subclause (VIII) of section 1902(a)(10)(A)(i), shall

not be considered to have in effect eligibility standards, methodologies, or procedures that are more restrictive than the standards, methodologies, or procedures in effect under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act for purposes of determining compliance with the requirements of paragraph (1), (2), or (3).''.

(c) MEDICAID BENCHMARK BENEFITS MUST CONSIST OF AT LEAST MINIMUM ESSENTIAL COVERAGE.—Section 1937(b) of such Act (42 U.S.C. 1396u–7(b)) is amended—

(1) in paragraph (1), in the matter preceding subparagraph (A), by inserting ''subject to paragraphs (5) and (6),'' before ''each'';

(2) in paragraph (2)—

(A) in the matter preceding subparagraph (A), by inserting ''subject to paragraphs (5) and (6)'' after ''subsection (a)(1),'';

(B) in subparagraph (A)—

(i) by redesignating clauses (iv) and (v) as clauses (vi) and (vii), respectively; and

(ii) by inserting after clause (iii), the following:

"(iv) Coverage of prescription drugs.

"(v) Mental health services."; and

(C) in subparagraph (C)—

(i) by striking clauses (i) and (ii); and

(ii) by redesignating clauses (iii) and (iv) as clauses (i) and (ii), respectively; and

(3) by adding at the end the following new paragraphs:

"(5) MINIMUM STANDARDS.—Effective January 1, 2014, any benchmark benefit package under paragraph (1) or benchmark equivalent coverage under paragraph (2) must provide at least essential health benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.

"(6) MENTAL HEALTH SERVICES PARITY.—

"(A) IN GENERAL.—In the case of any benchmark benefit package under paragraph (1) or benchmark equivalent coverage under paragraph (2) that is offered by an entity that is not a medicaid managed care organization and that provides both medical and surgical benefits and mental health or substance use disorder benefits, the entity shall ensure that the

1 financial requirements and treatment limita-
2 tions applicable to such mental health or sub-
3 stance use disorder benefits comply with the re-
4 quirements of section 2705(a) of the Public
5 Health Service Act in the same manner as such
6 requirements apply to a group health plan.

7 "(B) DEEMED COMPLIANCE.—Coverage
8 provided with respect to an individual described
9 in section 1905(a)(4)(B) and covered under the
10 State plan under section 1902(a)(10)(A) of the
11 services described in section 1905(a)(4)(B) (re-
12 lating to early and periodic screening, diag-
13 nostic, and treatment services defined in section
14 1905(r)) and provided in accordance with sec-
15 tion 1902(a)(43), shall be deemed to satisfy the
16 requirements of subparagraph (A).".

17 (d) ANNUAL REPORTS ON MEDICAID ENROLL-
18 MENT.—

19 (1) STATE REPORTS.—Section 1902(a) of the
20 Social Security Act (42 U.S.C. 1396a(a)), as amend-
21 ed by subsection (b), is amended—

22 (A) by striking "and" at the end of para-
23 graph (73);

24 (B) by striking the period at the end of
25 paragraph (74) and inserting "; and"; and

(C) by inserting after paragraph (74) the following new paragraph:

''(75) provide that, beginning January 2015, and annually thereafter, the State shall submit a report to the Secretary that contains—

''(A) the total number of enrolled and newly enrolled individuals in the State plan or under a waiver of the plan for the fiscal year ending on September 30 of the preceding calendar year, disaggregated by population, including children, parents, nonpregnant childless adults, disabled individuals, elderly individuals, and such other categories or sub-categories of individuals eligible for medical assistance under the State plan or under a waiver of the plan as the Secretary may require;

''(B) a description, which may be specified by population, of the outreach and enrollment processes used by the State during such fiscal year; and

''(C) any other data reporting determined necessary by the Secretary to monitor enrollment and retention of individuals eligible for medical assistance under the State plan or under a waiver of the plan.''.

1 (2) REPORTS TO CONGRESS.—Beginning April
2 2015, and annually thereafter, the Secretary of
3 Health and Human Services shall submit a report to
4 the appropriate committees of Congress on the total
5 enrollment and new enrollment in Medicaid for the
6 fiscal year ending on September 30 of the preceding
7 calendar year on a national and State-by-State
8 basis, and shall include in each such report such rec-
9 ommendations for administrative or legislative
10 changes to improve enrollment in the Medicaid pro-
11 gram as the Secretary determines appropriate.
12 (e) STATE OPTION FOR COVERAGE FOR INDIVIDUALS
13 WITH INCOME THAT EXCEEDS 133 PERCENT OF THE
14 POVERTY LINE.—
15 (1) COVERAGE AS OPTIONAL CATEGORICALLY
16 NEEDY GROUP.—Section 1902 of the Social Security
17 Act (42 U.S.C. 1396a) is amended—
18 (A) in subsection (a)(10)(A)(ii)—
19 (i) in subclause (XVIII), by striking
20 ''or'' at the end;
21 (ii) in subclause (XIX), by adding
22 ''or'' at the end; and
23 (iii) by adding at the end the fol-
24 lowing new subclause:

"(XX) beginning January 1, 2014, who are under 65 years of age and are not described in or enrolled under a previous subclause of this clause, and whose income (as determined under subsection (e)(14)) exceeds 133 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved but does not exceed the highest income eligibility level established under the State plan or under a waiver of the plan, subject to subsection (hh);" and

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

"(hh)(1) A State may elect to phase-in the extension of eligibility for medical assistance to individuals described in subclause (XX) of subsection (a)(10)(A)(ii) based on the categorical group (including nonpregnant childless adults) or income, so long as the State does not extend such eligibility to individuals described in such subclause with higher income before making individuals described in such subclause with lower income eligible for medical assistance.

1 "(2) If an individual described in subclause (XX) of
2 subsection (a)(10)(A)(ii) is the parent of a child who is
3 under 19 years of age (or such higher age as the State
4 may have elected) who is eligible for medical assistance
5 under the State plan or under a waiver of such plan, the
6 individual may not be enrolled under the State plan unless
7 the individual's child is enrolled under the State plan or
8 under a waiver of the plan or is enrolled in other health
9 insurance coverage. For purposes of the preceding sen-
10 tence, the term 'parent' includes an individual treated as
11 a caretaker relative for purposes of carrying out section
12 1931.".

13 (2) CONFORMING AMENDMENTS.—

14 (A) Section 1905(a) of such Act (42
15 U.S.C. 1396d(a)), as amended by subsection
16 (a)(5)(C), is amended in the matter preceding
17 paragraph (1)—

18 (i) by striking "or" at the end of
19 clause (xiii);

20 (ii) by inserting "or" at the end of
21 clause (xiv); and

22 (iii) by inserting after clause (xiv) the
23 following:

24 "(xv) individuals described in section
25 1902(a)(10)(A)(ii)(XX),".

(B) Section 1903(f)(4) of such Act (42 U.S.C. 1396b(f)(4)) is amended by inserting ''1902(a)(10)(A)(ii)(XX),'' after ''1902(a)(10)(A)(ii)(XIX),''.

(C) Section 1920(e) of such Act (42 U.S.C. 1396r–1(e)), as added by subsection (a)(4)(B), is amended by inserting ''or clause (ii)(XX)'' after ''clause (i)(VIII)''.

SEC. 2002. INCOME ELIGIBILITY FOR NONELDERLY DETERMINED USING MODIFIED GROSS INCOME.

(a) IN GENERAL.—Section 1902(e) of the Social Security Act (42 U.S.C. 1396a(e)) is amended by adding at the end the following:

''(14) INCOME DETERMINED USING MODIFIED GROSS INCOME.—

''(A) IN GENERAL.—Notwithstanding subsection (r) or any other provision of this title, except as provided in subparagraph (D), for purposes of determining income eligibility for medical assistance under the State plan or under any waiver of such plan and for any other purpose applicable under the plan or waiver for which a determination of income is required, including with respect to the imposition of premiums and cost-sharing, a State

1 shall use the modified gross income of an indi-
2 vidual and, in the case of an individual in a
3 family greater than 1, the household income of
4 such family. A State shall establish income eli-
5 gibility thresholds for populations to be eligible
6 for medical assistance under the State plan or
7 a waiver of the plan using modified gross in-
8 come and household income that are not less
9 than the effective income eligibility levels that
10 applied under the State plan or waiver on the
11 date of enactment of the Patient Protection and
12 Affordable Care Act. For purposes of complying
13 with the maintenance of effort requirements
14 under subsection (gg) during the transition to
15 modified gross income and household income, a
16 State shall, working with the Secretary, estab-
17 lish an equivalent income test that ensures indi-
18 viduals eligible for medical assistance under the
19 State plan or under a waiver of the plan on the
20 date of enactment of the Patient Protection and
21 Affordable Care Act, do not lose coverage under
22 the State plan or under a waiver of the plan.
23 The Secretary may waive such provisions of this
24 title and title XXI as are necessary to ensure

that States establish income and eligibility determination systems that protect beneficiaries.

"(B) NO INCOME OR EXPENSE DISREGARDS.—No type of expense, block, or other income disregard shall be applied by a State to determine income eligibility for medical assistance under the State plan or under any waiver of such plan or for any other purpose applicable under the plan or waiver for which a determination of income is required.

"(C) NO ASSETS TEST.—A State shall not apply any assets or resources test for purposes of determining eligibility for medical assistance under the State plan or under a waiver of the plan.

"(D) EXCEPTIONS.—

"(i) INDIVIDUALS ELIGIBLE BECAUSE OF OTHER AID OR ASSISTANCE, ELDERLY INDIVIDUALS, MEDICALLY NEEDY INDIVIDUALS, AND INDIVIDUALS ELIGIBLE FOR MEDICARE COST-SHARING.—Subparagraphs (A), (B), and (C) shall not apply to the determination of eligibility under the State plan or under a waiver for medical assistance for the following:

1 "(I) Individuals who are eligible
2 for medical assistance under the State
3 plan or under a waiver of the plan on
4 a basis that does not require a deter-
5 mination of income by the State agen-
6 cy administering the State plan or
7 waiver, including as a result of eligi-
8 bility for, or receipt of, other Federal
9 or State aid or assistance, individuals
10 who are eligible on the basis of receiv-
11 ing (or being treated as if receiving)
12 supplemental security income benefits
13 under title XVI, and individuals who
14 are eligible as a result of being or
15 being deemed to be a child in foster
16 care under the responsibility of the
17 State.
18 "(II) Individuals who have at-
19 tained age 65.
20 "(III) Individuals who qualify for
21 medical assistance under the State
22 plan or under any waiver of such plan
23 on the basis of being blind or disabled
24 (or being treated as being blind or
25 disabled) without regard to whether

the individual is eligible for supplemental security income benefits under title XVI on the basis of being blind or disabled and including an individual who is eligible for medical assistance on the basis of section 1902(e)(3).

"(IV) Individuals described in subsection (a)(10)(C).

"(V) Individuals described in any clause of subsection (a)(10)(E).

"(ii) EXPRESS LANE AGENCY FINDINGS.—In the case of a State that elects the Express Lane option under paragraph (13), notwithstanding subparagraphs (A), (B), and (C), the State may rely on a finding made by an Express Lane agency in accordance with that paragraph relating to the income of an individual for purposes of determining the individual's eligibility for medical assistance under the State plan or under a waiver of the plan.

"(iii) MEDICARE PRESCRIPTION DRUG SUBSIDIES DETERMINATIONS.—Subparagraphs (A), (B), and (C) shall not apply to

1 any determinations of eligibility for pre-
2 mium and cost-sharing subsidies under
3 and in accordance with section 1860D–14
4 made by the State pursuant to section
5 1935(a)(2).

6 "(iv) LONG-TERM CARE.—Subpara-
7 graphs (A), (B), and (C) shall not apply to
8 any determinations of eligibility of individ-
9 uals for purposes of medical assistance for
10 nursing facility services, a level of care in
11 any institution equivalent to that of nurs-
12 ing facility services, home or community-
13 based services furnished under a waiver or
14 State plan amendment under section 1915
15 or a waiver under section 1115, and serv-
16 ices described in section 1917(c)(1)(C)(ii).

17 "(v) GRANDFATHER OF CURRENT EN-
18 ROLLEES UNTIL DATE OF NEXT REGULAR
19 REDETERMINATION.—An individual who,
20 on January 1, 2014, is enrolled in the
21 State plan or under a waiver of the plan
22 and who would be determined ineligible for
23 medical assistance solely because of the ap-
24 plication of the modified gross income or
25 household income standard described in

1 subparagraph (A), shall remain eligible for
2 medical assistance under the State plan or
3 waiver (and subject to the same premiums
4 and cost-sharing as applied to the indi-
5 vidual on that date) through March 31,
6 2014, or the date on which the individual's
7 next regularly scheduled redetermination of
8 eligibility is to occur, whichever is later.
9 "(E) TRANSITION PLANNING AND OVER-
10 SIGHT.—Each State shall submit to the Sec-
11 retary for the Secretary's approval the income
12 eligibility thresholds proposed to be established
13 using modified gross income and household in-
14 come, the methodologies and procedures to be
15 used to determine income eligibility using modi-
16 fied gross income and household income and, if
17 applicable, a State plan amendment establishing
18 an optional eligibility category under subsection
19 (a)(10)(A)(ii)(XX). To the extent practicable,
20 the State shall use the same methodologies and
21 procedures for purposes of making such deter-
22 minations as the State used on the date of en-
23 actment of the Patient Protection and Afford-
24 able Care Act. The Secretary shall ensure that
25 the income eligibility thresholds proposed to be

established using modified gross income and household income, including under the eligibility category established under subsection (a)(10)(A)(ii)(XX), and the methodologies and procedures proposed to be used to determine income eligibility, will not result in children who would have been eligible for medical assistance under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act no longer being eligible for such assistance.

"(F) LIMITATION ON SECRETARIAL AUTHORITY.—The Secretary shall not waive compliance with the requirements of this paragraph except to the extent necessary to permit a State to coordinate eligibility requirements for dual eligible individuals (as defined in section 1915(h)(2)(B)) under the State plan or under a waiver of the plan and under title XVIII and individuals who require the level of care provided in a hospital, a nursing facility, or an intermediate care facility for the mentally retarded.

"(G) DEFINITIONS OF MODIFIED GROSS INCOME AND HOUSEHOLD INCOME.—In this

1 paragraph, the terms 'modified gross income'
2 and 'household income' have the meanings
3 given such terms in section 36B(d)(2) of the
4 Internal Revenue Code of 1986.

5 "(H) CONTINUED APPLICATION OF MED-
6 ICAID RULES REGARDING POINT-IN-TIME IN-
7 COME AND SOURCES OF INCOME.—The require-
8 ment under this paragraph for States to use
9 modified gross income and household income to
10 determine income eligibility for medical assist-
11 ance under the State plan or under any waiver
12 of such plan and for any other purpose applica-
13 ble under the plan or waiver for which a deter-
14 mination of income is required shall not be con-
15 strued as affecting or limiting the application
16 of—

17 "(i) the requirement under this title
18 and under the State plan or a waiver of
19 the plan to determine an individual's in-
20 come as of the point in time at which an
21 application for medical assistance under
22 the State plan or a waiver of the plan is
23 processed; or

24 "(ii) any rules established under this
25 title or under the State plan or a waiver of

the plan regarding sources of countable income.''.

(b) CONFORMING AMENDMENT.—Section 1902(a)(17) of such Act (42 U.S.C. 1396a(a)(17)) is amended by inserting ''(e)(14),'' before ''(l)(3)''.

(c) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) take effect on January 1, 2014.

SEC. 2003. REQUIREMENT TO OFFER PREMIUM ASSISTANCE FOR EMPLOYER-SPONSORED INSURANCE.

(a) IN GENERAL.—Section 1906A of such Act (42 U.S.C. 1396e–1) is amended—

(1) in subsection (a)—

(A) by striking ''may elect to'' and inserting ''shall'';

(B) by striking ''under age 19''; and

(C) by inserting '', in the case of an individual under age 19,'' after ''(and'';

(2) in subsection (c), in the first sentence, by striking ''under age 19''; and

(3) in subsection (d)—

(A) in paragraph (2)—

(i) in the first sentence, by striking ''under age 19''; and

(ii) by striking the third sentence and inserting "A State may not require, as a condition of an individual (or the individual's parent) being or remaining eligible for medical assistance under this title, that the individual (or the individual's parent) apply for enrollment in qualified employer-sponsored coverage under this section."; and

(B) in paragraph (3), by striking "the parent of an individual under age 19" and inserting "an individual (or the parent of an individual)"; and

(4) in subsection (e), by striking "under age 19" each place it appears.

(b) CONFORMING AMENDMENT.—The heading for section 1906A of such Act (42 U.S.C. 1396e–1) is amended by striking "OPTION FOR CHILDREN".

(c) EFFECTIVE DATE.—The amendments made by this section take effect on January 1, 2014.

SEC. 2004. MEDICAID COVERAGE FOR FORMER FOSTER CARE CHILDREN.

(a) IN GENERAL.—Section 1902(a)(10)(A)(i) of the Social Security Act (42 U.S.C. 1396a), as amended by section 2001(a)(1), is amended—

(1) by striking ''or'' at the end of subclause (VII);

(2) by adding ''or'' at the end of subclause (VIII); and

(3) by inserting after subclause (VIII) the following:

''(IX) who were in foster care under the responsibility of a State for more than 6 months (whether or not consecutive) but are no longer in such care, who are not described in any of subclauses (I) through (VII) of this clause, and who are under 25 years of age;''.

(b) OPTION TO PROVIDE PRESUMPTIVE ELIGIBILITY.—Section 1920(e) of such Act (42 U.S.C. 1396r–1(e)), as added by section 2001(a)(4)(B) and amended by section 2001(e)(2)(C), is amended by inserting '', clause (i)(IX),'' after ''clause (i)(VIII)''.

(c) CONFORMING AMENDMENTS.—

(1) Section 1903(f)(4) of such Act (42 U.S.C. 1396b(f)(4)), as amended by section 2001(a)(5)(D), is amended by inserting ''1902(a)(10)(A)(i)(IX),'' after ''1902(a)(10)(A)(i)(VIII),''.

(2) Section 1937(a)(2)(B)(viii) of such Act (42 U.S.C. 1396u–7(a)(2)(B)(viii)) is amended by inserting ", or the individual qualifies for medical assistance on the basis of section 1902(a)(10)(A)(i)(IX)" before the period.

(d) EFFECTIVE DATE.—The amendments made by this section take effect on January 1, 2019.

SEC. 2005. PAYMENTS TO TERRITORIES.

(a) INCREASE IN LIMIT ON PAYMENTS.—Section 1108(g) of the Social Security Act (42 U.S.C. 1308(g)) is amended—

(1) in paragraph (2), in the matter preceding subparagraph (A), by striking "paragraph (3)" and inserting "paragraphs (3) and (5)";

(2) in paragraph (4), by striking "and (3)" and inserting "(3), and (4)"; and

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

"(5) FISCAL YEAR 2011 AND THEREAFTER.—The amounts otherwise determined under this subsection for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa for the second, third, and fourth quarters of fiscal year 2011, and for each fiscal year after fiscal year 2011 (after the application of subsection (f) and the

preceding paragraphs of this subsection), shall be increased by 30 percent.''.

(b) DISREGARD OF PAYMENTS FOR MANDATORY EXPANDED ENROLLMENT.—Section 1108(g)(4) of such Act (42 U.S.C. 1308(g)(4)) is amended—

(1) by striking ''to fiscal years beginning'' and inserting ''to—

''(A) fiscal years beginning'';

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

(3) by adding at the end the following:

''(B) fiscal years beginning with fiscal year 2014, payments made to Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa with respect to amounts expended for medical assistance for newly eligible (as defined in section 1905(y)(2)) nonpregnant childless adults who are eligible under subclause (VIII) of section 1902(a)(10)(A)(i) and whose income (as determined under section 1902(e)(14)) does not exceed (in the case of each such commonwealth and territory respectively) the income eligibility level in effect for that population under title XIX or under a waiver on the date of enact-

ment of the Patient Protection and Affordable Care Act, shall not be taken into account in applying subsection (f) (as increased in accordance with paragraphs (1), (2), (3), and (5) of this subsection) to such commonwealth or territory for such fiscal year.''.

(c) INCREASED FMAP.—

(1) IN GENERAL.—The first sentence of section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) is amended by striking ''shall be 50 per centum'' and inserting ''shall be 55 percent''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) takes effect on January 1, 2011.

SEC. 2006. SPECIAL ADJUSTMENT TO FMAP DETERMINATION FOR CERTAIN STATES RECOVERING FROM A MAJOR DISASTER.

Section 1905 of the Social Security Act (42 U.S.C. 1396d), as amended by sections 2001(a)(3) and 2001(b)(2), is amended—

(1) in subsection (b), in the first sentence, by striking ''subsection (y)'' and inserting ''subsections (y) and (aa)''; and

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

1 "(aa)(1) Notwithstanding subsection (b), beginning
2 January 1, 2011, the Federal medical assistance percent-
3 age for a fiscal year for a disaster-recovery FMAP adjust-
4 ment State shall be equal to the following:

5 "(A) In the case of the first fiscal year (or part
6 of a fiscal year) for which this subsection applies to
7 the State, the Federal medical assistance percentage
8 determined for the fiscal year without regard to this
9 subsection and subsection (y), increased by 50 per-
10 cent of the number of percentage points by which
11 the Federal medical assistance percentage deter-
12 mined for the State for the fiscal year without re-
13 gard to this subsection and subsection (y), is less
14 than the Federal medical assistance percentage de-
15 termined for the State for the preceding fiscal year
16 after the application of only subsection (a) of section
17 5001 of Public Law 111–5 (if applicable to the pre-
18 ceding fiscal year) and without regard to this sub-
19 section, subsection (y), and subsections (b) and (c)
20 of section 5001 of Public Law 111–5.

21 "(B) In the case of the second or any suc-
22 ceeding fiscal year for which this subsection applies
23 to the State, the Federal medical assistance percent-
24 age determined for the preceding fiscal year under
25 this subsection for the State, increased by 25 per-

cent of the number of percentage points by which the Federal medical assistance percentage determined for the State for the fiscal year without regard to this subsection and subsection (y), is less than the Federal medical assistance percentage determined for the State for the preceding fiscal year under this subsection.

''(2) In this subsection, the term 'disaster-recovery FMAP adjustment State' means a State that is one of the 50 States or the District of Columbia, for which, at any time during the preceding 7 fiscal years, the President has declared a major disaster under section 401 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act and determined as a result of such disaster that every county or parish in the State warrant individual and public assistance or public assistance from the Federal Government under such Act and for which—

''(A) in the case of the first fiscal year (or part of a fiscal year) for which this subsection applies to the State, the Federal medical assistance percentage determined for the State for the fiscal year without regard to this subsection and subsection (y), is less than the Federal medical assistance percentage determined for the State for the preceding fiscal year after the application of only subsection (a) of section

5001 of Public Law 111–5 (if applicable to the preceding fiscal year) and without regard to this subsection, subsection (y), and subsections (b) and (c) of section 5001 of Public Law 111–5, by at least 3 percentage points; and

"(B) in the case of the second or any succeeding fiscal year for which this subsection applies to the State, the Federal medical assistance percentage determined for the State for the fiscal year without regard to this subsection and subsection (y), is less than the Federal medical assistance percentage determined for the State for the preceding fiscal year under this subsection by at least 3 percentage points.

"(3) The Federal medical assistance percentage determined for a disaster-recovery FMAP adjustment State under paragraph (1) shall apply for purposes of this title (other than with respect to disproportionate share hospital payments described in section 1923 and payments under this title that are based on the enhanced FMAP described in 2105(b)) and shall not apply with respect to payments under title IV (other than under part E of title IV) or payments under title XXI.".

SEC. 2007. MEDICAID IMPROVEMENT FUND RESCISSION.

(a) RESCISSION.—Any amounts available to the Medicaid Improvement Fund established under section 1941 of the Social Security Act (42 U.S.C. 1396w–1) for any of fiscal years 2014 through 2018 that are available for expenditure from the Fund and that are not so obligated as of the date of the enactment of this Act are rescinded.

(b) CONFORMING AMENDMENTS.—Section 1941(b)(1) of the Social Security Act (42 U.S.C. 1396w–1(b)(1)) is amended—

(1) in subparagraph (A), by striking "$100,000,000" and inserting "$0"; and

(2) in subparagraph (B), by striking "$150,000,000" and inserting "$0".

Subtitle B—Enhanced Support for the Children's Health Insurance Program

SEC. 2101. ADDITIONAL FEDERAL FINANCIAL PARTICIPATION FOR CHIP.

(a) IN GENERAL.—Section 2105(b) of the Social Security Act (42 U.S.C. 1397ee(b)) is amended by adding at the end the following: "Notwithstanding the preceding sentence, during the period that begins on October 1, 2013, and ends on September 30, 2019, the enhanced FMAP determined for a State for a fiscal year (or for any portion of a fiscal year occurring during such period)

1 shall be increased by 23 percentage points, but in no case
2 shall exceed 100 percent. The increase in the enhanced
3 FMAP under the preceding sentence shall not apply with
4 respect to determining the payment to a State under sub-
5 section (a)(1) for expenditures described in subparagraph
6 (D)(iv), paragraphs (8), (9), (11) of subsection (c), or
7 clause (4) of the first sentence of section 1905(b).''.

8 (b) MAINTENANCE OF EFFORT.—

9 (1) IN GENERAL.—Section 2105(d) of the So-
10 cial Security Act (42 U.S.C. 1397ee(d)) is amended
11 by adding at the end the following:

12 ''(3) CONTINUATION OF ELIGIBILITY STAND-
13 ARDS FOR CHILDREN UNTIL OCTOBER 1, 2019.—

14 ''(A) IN GENERAL.—During the period
15 that begins on the date of enactment of the Pa-
16 tient Protection and Affordable Care Act and
17 ends on September 30, 2019, a State shall not
18 have in effect eligibility standards, methodolo-
19 gies, or procedures under its State child health
20 plan (including any waiver under such plan) for
21 children (including children provided medical
22 assistance for which payment is made under
23 section 2105(a)(1)(A)) that are more restrictive
24 than the eligibility standards, methodologies, or
25 procedures, respectively, under such plan (or

waiver) as in effect on the date of enactment of that Act. The preceding sentence shall not be construed as preventing a State during such period from—

"(i) applying eligibility standards, methodologies, or procedures for children under the State child health plan or under any waiver of the plan that are less restrictive than the eligibility standards, methodologies, or procedures, respectively, for children under the plan or waiver that are in effect on the date of enactment of such Act; or

"(ii) imposing a limitation described in section 2112(b)(7) for a fiscal year in order to limit expenditures under the State child health plan to those for which Federal financial participation is available under this section for the fiscal year.

"(B) ASSURANCE OF EXCHANGE COVERAGE FOR TARGETED LOW-INCOME CHILDREN UNABLE TO BE PROVIDED CHILD HEALTH ASSISTANCE AS A RESULT OF FUNDING SHORTFALLS.—In the event that allotments provided under section 2104 are insufficient to provide

coverage to all children who are eligible to be targeted low-income children under the State child health plan under this title, a State shall establish procedures to ensure that such children are provided coverage through an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act.''.

(2) CONFORMING AMENDMENT TO TITLE XXI MEDICAID MAINTENANCE OF EFFORT.—Section 2105(d)(1) of the Social Security Act (42 U.S.C. 1397ee(d)(1)) is amended by adding before the period '', except as required under section 1902(e)(14)''.

(c) NO ENROLLMENT BONUS PAYMENTS FOR CHILDREN ENROLLED AFTER FISCAL YEAR 2013.—Section 2105(a)(3)(F)(iii) of the Social Security Act (42 U.S.C. 1397ee(a)(3)(F)(iii)) is amended by inserting ''or any children enrolled on or after October 1, 2013'' before the period.

(d) INCOME ELIGIBILITY DETERMINED USING MODIFIED GROSS INCOME.—

(1) STATE PLAN REQUIREMENT.—Section 2102(b)(1)(B) of the Social Security Act (42 U.S.C. 1397bb(b)(1)(B)) is amended—

(A) in clause (iii), by striking ''and'' after the semicolon;

(B) in clause (iv), by striking the period and inserting ''; and''; and

(C) by adding at the end the following:

''(v) shall, beginning January 1, 2014, use modified gross income and household income (as defined in section 36B(d)(2) of the Internal Revenue Code of 1986) to determine eligibility for child health assistance under the State child health plan or under any waiver of such plan and for any other purpose applicable under the plan or waiver for which a determination of income is required, including with respect to the imposition of premiums and cost-sharing, consistent with section 1902(e)(14).''.

(2) CONFORMING AMENDMENT.—Section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397gg(e)(1)) is amended—

(A) by redesignating subparagraphs (E) through (L) as subparagraphs (F) through (M), respectively; and

(B) by inserting after subparagraph (D), the following:

"(E) Section 1902(e)(14) (relating to income determined using modified gross income and household income).".

(e) APPLICATION OF STREAMLINED ENROLLMENT SYSTEM.—Section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397gg(e)(1)), as amended by subsection (d)(2), is amended by adding at the end the following:

"(N) Section 1943(b) (relating to coordination with State Exchanges and the State Medicaid agency).".

(f) CHIP ELIGIBILITY FOR CHILDREN INELIGIBLE FOR MEDICAID AS A RESULT OF ELIMINATION OF DISREGARDS.—Notwithstanding any other provision of law, a State shall treat any child who is determined to be ineligible for medical assistance under the State Medicaid plan or under a waiver of the plan as a result of the elimination of the application of an income disregard based on expense or type of income, as required under section 1902(e)(14) of the Social Security Act (as added by this Act), as a targeted low-income child under section 2110(b) (unless the child is excluded under paragraph (2) of that section) and shall provide child health assistance to the child under the State child health plan (whether implemented under title XIX or XXI, or both, of the Social Security Act).

SEC. 2102. TECHNICAL CORRECTIONS.

(a) CHIPRA.—Effective as if included in the enactment of the Children's Health Insurance Program Reauthorization Act of 2009 (Public Law 111–3) (in this section referred to as "CHIPRA"):

(1) Section 2104(m) of the Social Security Act, as added by section 102 of CHIPRA, is amended—

(A) by redesignating paragraph (7) as paragraph (8); and

(B) by inserting after paragraph (6), the following:

"(7) ADJUSTMENT OF FISCAL YEAR 2010 ALLOTMENTS TO ACCOUNT FOR CHANGES IN PROJECTED SPENDING FOR CERTAIN PREVIOUSLY APPROVED EXPANSION PROGRAMS.—For purposes of recalculating the fiscal year 2010 allotment, in the case of one of the 50 States or the District of Columbia that has an approved State plan amendment effective January 1, 2006, to provide child health assistance through the provision of benefits under the State plan under title XIX for children from birth through age 5 whose family income does not exceed 200 percent of the poverty line, the Secretary shall increase the allotment by an amount that would be equal to the Federal share of expenditures that would have been claimed at the enhanced FMAP

rate rather than the Federal medical assistance percentage matching rate for such population.''.

(2) Section 605 of CHIPRA is amended by striking ''legal residents'' and insert ''lawfully residing in the United States''.

(3) Subclauses (I) and (II) of paragraph (3)(C)(i) of section 2105(a) of the Social Security Act (42 U.S.C. 1397ee(a)(3)(ii)), as added by section 104 of CHIPRA, are each amended by striking '', respectively''.

(4) Section 2105(a)(3)(E)(ii) of the Social Security Act (42 U.S.C. 1397ee(a)(3)(E)(ii)), as added by section 104 of CHIPRA, is amended by striking subclause (IV).

(5) Section 2105(c)(9)(B) of the Social Security Act (42 U.S.C. 1397e(c)(9)(B)), as added by section 211(c)(1) of CHIPRA, is amended by striking ''section 1903(a)(3)(F)'' and inserting ''section 1903(a)(3)(G)''.

(6) Section 2109(b)(2)(B) of the Social Security Act (42 U.S.C. 1397ii(b)(2)(B)), as added by section 602 of CHIPRA, is amended by striking ''the child population growth factor under section 2104(m)(5)(B)'' and inserting ''a high-performing State under section 2111(b)(3)(B)''.

(7) Section 2110(c)(9)(B)(v) of the Social Security Act (42 U.S.C. 1397jj(c)(9)(B)(v)), as added by section 505(b) of CHIPRA, is amended by striking ''school or school system'' and inserting ''local educational agency (as defined under section 9101 of the Elementary and Secondary Education Act of 1965''.

(8) Section 211(a)(1)(B) of CHIPRA is amended—

(A) by striking ''is amended'' and all that follows through ''adding'' and inserting ''is amended by adding''; and

(B) by redesignating the new subparagraph to be added by such section to section 1903(a)(3) of the Social Security Act as a new subparagraph (H).

(b) ARRA.—Effective as if included in the enactment of section 5006(a) of division B of the American Recovery and Reinvestment Act of 2009 (Public Law 111–5), the second sentence of section 1916A(a)(1) of the Social Security Act (42 U.S.C. 1396o–1(a)(1)) is amended by striking ''or (i)'' and inserting '', (i), or (j)''.

Subtitle C—Medicaid and CHIP Enrollment Simplification

SEC. 2201. ENROLLMENT SIMPLIFICATION AND COORDINATION WITH STATE HEALTH INSURANCE EXCHANGES.

Title XIX of the Social Security Act (42 U.S.C. 1397aa et seq.) is amended by adding at the end the following:

"SEC. 1943. ENROLLMENT SIMPLIFICATION AND COORDINATION WITH STATE HEALTH INSURANCE EXCHANGES.

"(a) CONDITION FOR PARTICIPATION IN MEDICAID.—As a condition of the State plan under this title and receipt of any Federal financial assistance under section 1903(a) for calendar quarters beginning after January 1, 2014, a State shall ensure that the requirements of subsection (b) is met.

"(b) ENROLLMENT SIMPLIFICATION AND COORDINATION WITH STATE HEALTH INSURANCE EXCHANGES AND CHIP.—

"(1) IN GENERAL.—A State shall establish procedures for—

"(A) enabling individuals, through an Internet website that meets the requirements of paragraph (4), to apply for medical assistance

1 under the State plan or under a waiver of the
2 plan, to be enrolled in the State plan or waiver,
3 to renew their enrollment in the plan or waiver,
4 and to consent to enrollment or reenrollment in
5 the State plan through electronic signature;
6 ''(B) enrolling, without any further deter-
7 mination by the State and through such
8 website, individuals who are identified by an
9 Exchange established by the State under sec-
10 tion 1311 of the Patient Protection and Afford-
11 able Care Act as being eligible for—
12 ''(i) medical assistance under the
13 State plan or under a waiver of the plan;
14 or
15 ''(ii) child health assistance under the
16 State child health plan under title XXI;
17 ''(C) ensuring that individuals who apply
18 for but are determined to be ineligible for med-
19 ical assistance under the State plan or a waiver
20 or ineligible for child health assistance under
21 the State child health plan under title XXI, are
22 screened for eligibility for enrollment in quali-
23 fied health plans offered through such an Ex-
24 change and, if applicable, premium assistance
25 for the purchase of a qualified health plan

1 under section 36B of the Internal Revenue
2 Code of 1986 (and, if applicable, advance pay-
3 ment of such assistance under section 1412 of
4 the Patient Protection and Affordable Care
5 Act), and, if eligible, enrolled in such a plan
6 without having to submit an additional or sepa-
7 rate application, and that such individuals re-
8 ceive information regarding reduced cost-shar-
9 ing for eligible individuals under section 1402
10 of the Patient Protection and Affordable Care
11 Act, and any other assistance or subsidies avail-
12 able for coverage obtained through the Ex-
13 change;

14 ''(D) ensuring that the State agency re-
15 sponsible for administering the State plan
16 under this title (in this section referred to as
17 the 'State Medicaid agency'), the State agency
18 responsible for administering the State child
19 health plan under title XXI (in this section re-
20 ferred to as the 'State CHIP agency') and an
21 Exchange established by the State under sec-
22 tion 1311 of the Patient Protection and Afford-
23 able Care Act utilize a secure electronic inter-
24 face sufficient to allow for a determination of
25 an individual's eligibility for such medical as-

1 sistance, child health assistance, or premium
2 assistance, and enrollment in the State plan
3 under this title, title XXI, or a qualified health
4 plan, as appropriate;
5 ''(E) coordinating, for individuals who are
6 enrolled in the State plan or under a waiver of
7 the plan and who are also enrolled in a quali-
8 fied health plan offered through such an Ex-
9 change, and for individuals who are enrolled in
10 the State child health plan under title XXI and
11 who are also enrolled in a qualified health plan,
12 the provision of medical assistance or child
13 health assistance to such individuals with the
14 coverage provided under the qualified health
15 plan in which they are enrolled, including serv-
16 ices described in section 1905(a)(4)(B) (relating
17 to early and periodic screening, diagnostic, and
18 treatment services defined in section 1905(r))
19 and provided in accordance with the require-
20 ments of section 1902(a)(43); and
21 ''(F) conducting outreach to and enrolling
22 vulnerable and underserved populations eligible
23 for medical assistance under this title XIX or
24 for child health assistance under title XXI, in-
25 cluding children, unaccompanied homeless

1 youth, children and youth with special health
2 care needs, pregnant women, racial and ethnic
3 minorities, rural populations, victims of abuse
4 or trauma, individuals with mental health or
5 substance-related disorders, and individuals
6 with HIV/AIDS.

7 "(2) AGREEMENTS WITH STATE HEALTH IN-
8 SURANCE EXCHANGES.—The State Medicaid agency
9 and the State CHIP agency may enter into an
10 agreement with an Exchange established by the
11 State under section 1311 of the Patient Protection
12 and Affordable Care Act under which the State
13 Medicaid agency or State CHIP agency may deter-
14 mine whether a State resident is eligible for pre-
15 mium assistance for the purchase of a qualified
16 health plan under section 36B of the Internal Rev-
17 enue Code of 1986 (and, if applicable, advance pay-
18 ment of such assistance under section 1412 of the
19 Patient Protection and Affordable Care Act), so long
20 as the agreement meets such conditions and require-
21 ments as the Secretary of the Treasury may pre-
22 scribe to reduce administrative costs and the likeli-
23 hood of eligibility errors and disruptions in coverage.

24 "(3) STREAMLINED ENROLLMENT SYSTEM.—
25 The State Medicaid agency and State CHIP agency

1 shall participate in and comply with the require-
2 ments for the system established under section 1413
3 of the Patient Protection and Affordable Care Act
4 (relating to streamlined procedures for enrollment
5 through an Exchange, Medicaid, and CHIP).

6 "(4) ENROLLMENT WEBSITE REQUIREMENTS.—
7 The procedures established by State under para-
8 graph (1) shall include establishing and having in
9 operation, not later than January 1, 2014, an Inter-
10 net website that is linked to any website of an Ex-
11 change established by the State under section 1311
12 of the Patient Protection and Affordable Care Act
13 and to the State CHIP agency (if different from the
14 State Medicaid agency) and allows an individual who
15 is eligible for medical assistance under the State
16 plan or under a waiver of the plan and who is eligi-
17 ble to receive premium credit assistance for the pur-
18 chase of a qualified health plan under section 36B
19 of the Internal Revenue Code of 1986 to compare
20 the benefits, premiums, and cost-sharing applicable
21 to the individual under the State plan or waiver with
22 the benefits, premiums, and cost-sharing available to
23 the individual under a qualified health plan offered
24 through such an Exchange, including, in the case of
25 a child, the coverage that would be provided for the

1 child through the State plan or waiver with the cov-
2 erage that would be provided to the child through
3 enrollment in family coverage under that plan and
4 as supplemental coverage by the State under the
5 State plan or waiver.

6 "(5) CONTINUED NEED FOR ASSESSMENT FOR
7 HOME AND COMMUNITY-BASED SERVICES.—Nothing
8 in paragraph (1) shall limit or modify the require-
9 ment that the State assess an individual for pur-
10 poses of providing home and community-based serv-
11 ices under the State plan or under any waiver of
12 such plan for individuals described in subsection
13 (a)(10)(A)(ii)(VI).".

14 **SEC. 2202. PERMITTING HOSPITALS TO MAKE PRESUMP-**
15 **TIVE ELIGIBILITY DETERMINATIONS FOR**
16 **ALL MEDICAID ELIGIBLE POPULATIONS.**

17 (a) IN GENERAL.—Section 1902(a)(47) of the Social
18 Security Act (42 U.S.C. 1396a(a)(47)) is amended—

19 (1) by striking "at the option of the State, pro-
20 vide" and inserting "provide—

21 "(A) at the option of the State,";

22 (2) by inserting "and" after the semicolon; and

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

24 "(B) that any hospital that is a partici-
25 pating provider under the State plan may elect

to be a qualified entity for purposes of determining, on the basis of preliminary information, whether any individual is eligible for medical assistance under the State plan or under a waiver of the plan for purposes of providing the individual with medical assistance during a presumptive eligibility period, in the same manner, and subject to the same requirements, as apply to the State options with respect to populations described in section 1920, 1920A, or 1920B (but without regard to whether the State has elected to provide for a presumptive eligibility period under any such sections), subject to such guidance as the Secretary shall establish;''.

(b) CONFORMING AMENDMENT.—Section 1903(u)(1)(D)(v) of such Act (42 U.S.C. 1396b(u)(1)(D)v)) is amended—

(1) by striking ''or for'' and inserting ''for''; and

(2) by inserting before the period at the end the following: '', or for medical assistance provided to an individual during a presumptive eligibility period resulting from a determination of presumptive eligibility made by a hospital that elects under section

1902(a)(47)(B) to be a qualified entity for such purpose''.

(c) EFFECTIVE DATE.—The amendments made by this section take effect on January 1, 2014, and apply to services furnished on or after that date.

Subtitle D—Improvements to Medicaid Services

SEC. 2301. COVERAGE FOR FREESTANDING BIRTH CENTER SERVICES.

(a) IN GENERAL.—Section 1905 of the Social Security Act (42 U.S.C. 1396d), is amended—

(1) in subsection (a)—

(A) in paragraph (27), by striking ''and'' at the end;

(B) by redesignating paragraph (28) as paragraph (29); and

(C) by inserting after paragraph (27) the following new paragraph:

''(28) freestanding birth center services (as defined in subsection (l)(3)(A)) and other ambulatory services that are offered by a freestanding birth center (as defined in subsection (l)(3)(B)) and that are otherwise included in the plan; and''; and

(2) in subsection (l), by adding at the end the following new paragraph:

1 "(3)(A) The term 'freestanding birth center services'
2 means services furnished to an individual at a freestanding
3 birth center (as defined in subparagraph (B)) at such cen-
4 ter.
5 "(B) The term 'freestanding birth center' means a
6 health facility—
7 "(i) that is not a hospital;
8 "(ii) where childbirth is planned to occur away
9 from the pregnant woman's residence;
10 "(iii) that is licensed or otherwise approved by
11 the State to provide prenatal labor and delivery or
12 postpartum care and other ambulatory services that
13 are included in the plan; and
14 "(iv) that complies with such other require-
15 ments relating to the health and safety of individuals
16 furnished services by the facility as the State shall
17 establish.
18 "(C) A State shall provide separate payments to pro-
19 viders administering prenatal labor and delivery or
20 postpartum care in a freestanding birth center (as defined
21 in subparagraph (B)), such as nurse midwives and other
22 providers of services such as birth attendants recognized
23 under State law, as determined appropriate by the Sec-
24 retary. For purposes of the preceding sentence, the term
25 'birth attendant' means an individual who is recognized

1 or registered by the State involved to provide health care
2 at childbirth and who provides such care within the scope
3 of practice under which the individual is legally authorized
4 to perform such care under State law (or the State regu-
5 latory mechanism provided by State law), regardless of
6 whether the individual is under the supervision of, or asso-
7 ciated with, a physician or other health care provider.
8 Nothing in this subparagraph shall be construed as chang-
9 ing State law requirements applicable to a birth attend-
10 ant.''.

11 (b) CONFORMING AMENDMENT.—Section
12 1902(a)(10)(A) of the Social Security Act (42 U.S.C.
13 1396a(a)(10)(A)), is amended in the matter preceding
14 clause (i) by striking ''and (21)'' and inserting '', (21),
15 and (28)''.

16 (c) EFFECTIVE DATE.—

17 (1) IN GENERAL.—Except as provided in para-
18 graph (2), the amendments made by this section
19 shall take effect on the date of the enactment of this
20 Act and shall apply to services furnished on or after
21 such date.

22 (2) EXCEPTION IF STATE LEGISLATION RE-
23 QUIRED.—In the case of a State plan for medical as-
24 sistance under title XIX of the Social Security Act
25 which the Secretary of Health and Human Services

determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirement imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 2302. CONCURRENT CARE FOR CHILDREN.

(a) IN GENERAL.—Section 1905(o)(1) of the Social Security Act (42 U.S.C. 1396d(o)(1)) is amended—

(1) in subparagraph (A), by striking ''subparagraph (B)'' and inserting ''subparagraphs (B) and (C)''; and

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

''(C) A voluntary election to have payment made for hospice care for a child (as defined by the State) shall

not constitute a waiver of any rights of the child to be provided with, or to have payment made under this title for, services that are related to the treatment of the child's condition for which a diagnosis of terminal illness has been made.''.

(b) APPLICATION TO CHIP.—Section 2110(a)(23) of the Social Security Act (42 U.S.C. 1397jj(a)(23)) is amended by inserting ''(concurrent, in the case of an individual who is a child, with care related to the treatment of the child's condition with respect to which a diagnosis of terminal illness has been made'' after ''hospice care''.

SEC. 2303. STATE ELIGIBILITY OPTION FOR FAMILY PLANNING SERVICES.

(a) COVERAGE AS OPTIONAL CATEGORICALLY NEEDY GROUP.—

(1) IN GENERAL.—Section 1902(a)(10)(A)(ii) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)), as amended by section 2001(e), is amended—

(A) in subclause (XIX), by striking ''or'' at the end;

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

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

1 "(XXI) who are described in sub-
2 section (ii) (relating to individuals
3 who meet certain income standards);".
4 (2) GROUP DESCRIBED.—Section 1902 of such
5 Act (42 U.S.C. 1396a), as amended by section
6 2001(d), is amended by adding at the end the fol-
7 lowing new subsection:
8 "(ii)(1) Individuals described in this subsection are
9 individuals—
10 "(A) whose income does not exceed an in-
11 come eligibility level established by the State
12 that does not exceed the highest income eligi-
13 bility level established under the State plan
14 under this title (or under its State child health
15 plan under title XXI) for pregnant women; and
16 "(B) who are not pregnant.
17 "(2) At the option of a State, individuals de-
18 scribed in this subsection may include individuals
19 who, had individuals applied on or before January 1,
20 2007, would have been made eligible pursuant to the
21 standards and processes imposed by that State for
22 benefits described in clause (XV) of the matter fol-
23 lowing subparagraph (G) of section subsection
24 (a)(10) pursuant to a waiver granted under section
25 1115.

"(3) At the option of a State, for purposes of subsection (a)(17)(B), in determining eligibility for services under this subsection, the State may consider only the income of the applicant or recipient.".

(3) LIMITATION ON BENEFITS.—Section 1902(a)(10) of the Social Security Act (42 U.S.C. 1396a(a)(10)), as amended by section 2001(a)(5)(A), is amended in the matter following subparagraph (G)—

(A) by striking "and (XV)" and inserting "(XV)"; and

(B) by inserting ", and (XVI) the medical assistance made available to an individual described in subsection (ii) shall be limited to family planning services and supplies described in section 1905(a)(4)(C) including medical diagnosis and treatment services that are provided pursuant to a family planning service in a family planning setting" before the semicolon.

(4) CONFORMING AMENDMENTS.—

(A) Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)), as amended by section 2001(e)(2)(A), is amended in the matter preceding paragraph (1)—

(i) in clause (xiv), by striking ''or'' at the end;

(ii) in clause (xv), by adding ''or'' at the end; and

(iii) by inserting after clause (xv) the following:

''(xvi) individuals described in section 1902(ii),''.

(B) Section 1903(f)(4) of such Act (42 U.S.C. 1396b(f)(4)), as amended by section 2001(e)(2)(B), is amended by inserting ''1902(a)(10)(A)(ii)(XXI),'' after ''1902(a)(10)(A)(ii)(XX),''.

(b) PRESUMPTIVE ELIGIBILITY.—

(1) IN GENERAL.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended by inserting after section 1920B the following:

''PRESUMPTIVE ELIGIBILITY FOR FAMILY PLANNING SERVICES

''SEC. 1920C. (a) STATE OPTION.—State plan approved under section 1902 may provide for making medical assistance available to an individual described in section 1902(ii) (relating to individuals who meet certain income eligibility standard) during a presumptive eligibility period. In the case of an individual described in section 1902(ii), such medical assistance shall be limited to family

1 planning services and supplies described in 1905(a)(4)(C)
2 and, at the State's option, medical diagnosis and treat-
3 ment services that are provided in conjunction with a fam-
4 ily planning service in a family planning setting.

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

6 "(1) PRESUMPTIVE ELIGIBILITY PERIOD.—The
7 term 'presumptive eligibility period' means, with re-
8 spect to an individual described in subsection (a),
9 the period that—

10 "(A) begins with the date on which a
11 qualified entity determines, on the basis of pre-
12 liminary information, that the individual is de-
13 scribed in section 1902(ii); and

14 "(B) ends with (and includes) the earlier
15 of—

16 "(i) the day on which a determination
17 is made with respect to the eligibility of
18 such individual for services under the State
19 plan; or

20 "(ii) in the case of such an individual
21 who does not file an application by the last
22 day of the month following the month dur-
23 ing which the entity makes the determina-
24 tion referred to in subparagraph (A), such
25 last day.

1 "(2) QUALIFIED ENTITY.—
2 "(A) IN GENERAL.—Subject to subpara-
3 graph (B), the term 'qualified entity' means
4 any entity that—
5 "(i) is eligible for payments under a
6 State plan approved under this title; and
7 "(ii) is determined by the State agen-
8 cy to be capable of making determinations
9 of the type described in paragraph (1)(A).
10 "(B) RULE OF CONSTRUCTION.—Nothing
11 in this paragraph shall be construed as pre-
12 venting a State from limiting the classes of en-
13 tities that may become qualified entities in
14 order to prevent fraud and abuse.
15 "(c) ADMINISTRATION.—
16 "(1) IN GENERAL.—The State agency shall pro-
17 vide qualified entities with—
18 "(A) such forms as are necessary for an
19 application to be made by an individual de-
20 scribed in subsection (a) for medical assistance
21 under the State plan; and
22 "(B) information on how to assist such in-
23 dividuals in completing and filing such forms.
24 "(2) NOTIFICATION REQUIREMENTS.—A quali-
25 fied entity that determines under subsection

1 (b)(1)(A) that an individual described in subsection
2 (a) is presumptively eligible for medical assistance
3 under a State plan shall—
4 "(A) notify the State agency of the deter-
5 mination within 5 working days after the date
6 on which determination is made; and
7 "(B) inform such individual at the time
8 the determination is made that an application
9 for medical assistance is required to be made by
10 not later than the last day of the month fol-
11 lowing the month during which the determina-
12 tion is made.
13 "(3) APPLICATION FOR MEDICAL ASSIST-
14 ANCE.—In the case of an individual described in
15 subsection (a) who is determined by a qualified enti-
16 ty to be presumptively eligible for medical assistance
17 under a State plan, the individual shall apply for
18 medical assistance by not later than the last day of
19 the month following the month during which the de-
20 termination is made.
21 "(d) PAYMENT.—Notwithstanding any other provi-
22 sion of law, medical assistance that—
23 "(1) is furnished to an individual described in
24 subsection (a)—

"(A) during a presumptive eligibility period; and

"(B) by a entity that is eligible for payments under the State plan; and

"(2) is included in the care and services covered by the State plan,

shall be treated as medical assistance provided by such plan for purposes of clause (4) of the first sentence of section 1905(b).".

(2) CONFORMING AMENDMENTS.—

(A) Section 1902(a)(47) of the Social Security Act (42 U.S.C. 1396a(a)(47)), as amended by section 2202(a), is amended—

(i) in subparagraph (A), by inserting before the semicolon at the end the following: "and provide for making medical assistance available to individuals described in subsection (a) of section 1920C during a presumptive eligibility period in accordance with such section"; and

(ii) in subparagraph (B), by striking "or 1920B" and inserting "1920B, or 1920C".

(B) Section 1903(u)(1)(D)(v) of such Act (42 U.S.C. 1396b(u)(1)(D)(v)), as amended by

1 section 2202(b), is amended by inserting ''or
2 for medical assistance provided to an individual
3 described in subsection (a) of section 1920C
4 during a presumptive eligibility period under
5 such section,'' after ''1920B during a presump-
6 tive eligibility period under such section,''.

7 (c) CLARIFICATION OF COVERAGE OF FAMILY PLAN-
8 NING SERVICES AND SUPPLIES.—Section 1937(b) of the
9 Social Security Act (42 U.S.C. 1396u–7(b)), as amended
10 by section 2001(c), is amended by adding at the end the
11 following:

12 ''(7) COVERAGE OF FAMILY PLANNING SERV-
13 ICES AND SUPPLIES.—Notwithstanding the previous
14 provisions of this section, a State may not provide
15 for medical assistance through enrollment of an indi-
16 vidual with benchmark coverage or benchmark-equiv-
17 alent coverage under this section unless such cov-
18 erage includes for any individual described in section
19 1905(a)(4)(C), medical assistance for family plan-
20 ning services and supplies in accordance with such
21 section.''.

22 (d) EFFECTIVE DATE.—The amendments made by
23 this section take effect on the date of the enactment of
24 this Act and shall apply to items and services furnished
25 on or after such date.

SEC. 2304. CLARIFICATION OF DEFINITION OF MEDICAL ASSISTANCE.

Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) is amended by inserting ''or the care and services themselves, or both'' before ''(if provided in or after''.

Subtitle E—New Options for States to Provide Long-Term Services and Supports

SEC. 2401. COMMUNITY FIRST CHOICE OPTION.

Section 1915 of the Social Security Act (42 U.S.C. 1396n) is amended by adding at the end the following:

''(k) STATE PLAN OPTION TO PROVIDE HOME AND COMMUNITY-BASED ATTENDANT SERVICES AND SUPPORTS.—

''(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, beginning October 1, 2010, a State may provide through a State plan amendment for the provision of medical assistance for home and community-based attendant services and supports for individuals who are eligible for medical assistance under the State plan whose income does not exceed 150 percent of the poverty line (as defined in section 2110(c)(5)) or, if greater, the income level applicable for an individual who has been determined to require an institutional level of care to be eligible for nursing facility services under

1 the State plan and with respect to whom there has
2 been a determination that, but for the provision of
3 such services, the individuals would require the level
4 of care provided in a hospital, a nursing facility, an
5 intermediate care facility for the mentally retarded,
6 or an institution for mental diseases, the cost of
7 which could be reimbursed under the State plan, but
8 only if the individual chooses to receive such home
9 and community-based attendant services and sup-
10 ports, and only if the State meets the following re-
11 quirements:

12 "(A) AVAILABILITY.—The State shall
13 make available home and community-based at-
14 tendant services and supports to eligible indi-
15 viduals, as needed, to assist in accomplishing
16 activities of daily living, instrumental activities
17 of daily living, and health-related tasks through
18 hands-on assistance, supervision, or cueing—

19 "(i) under a person-centered plan of
20 services and supports that is based on an
21 assessment of functional need and that is
22 agreed to in writing by the individual or,
23 as appropriate, the individual's representa-
24 tive;

1 "(ii) in a home or community setting,
2 which does not include a nursing facility,
3 institution for mental diseases, or an inter-
4 mediate care facility for the mentally re-
5 tarded;
6 "(iii) under an agency-provider model
7 or other model (as defined in paragraph
8 (6)(C)); and
9 "(iv) the furnishing of which—
10 "(I) is selected, managed, and
11 dismissed by the individual, or, as ap-
12 propriate, with assistance from the in-
13 dividual's representative;
14 "(II) is controlled, to the max-
15 imum extent possible, by the indi-
16 vidual or where appropriate, the indi-
17 vidual's representative, regardless of
18 who may act as the employer of
19 record; and
20 "(III) provided by an individual
21 who is qualified to provide such serv-
22 ices, including family members (as de-
23 fined by the Secretary).
24 "(B) INCLUDED SERVICES AND SUP-
25 PORTS.—In addition to assistance in accom-

1 plishing activities of daily living, instrumental
2 activities of daily living, and health related
3 tasks, the home and community-based attend-
4 ant services and supports made available in-
5 clude—
6 "(i) the acquisition, maintenance, and
7 enhancement of skills necessary for the in-
8 dividual to accomplish activities of daily
9 living, instrumental activities of daily liv-
10 ing, and health related tasks;
11 "(ii) back-up systems or mechanisms
12 (such as the use of beepers or other elec-
13 tronic devices) to ensure continuity of serv-
14 ices and supports; and
15 "(iii) voluntary training on how to se-
16 lect, manage, and dismiss attendants.
17 "(C) EXCLUDED SERVICES AND SUP-
18 PORTS.—Subject to subparagraph (D), the
19 home and community-based attendant services
20 and supports made available do not include—
21 "(i) room and board costs for the in-
22 dividual;
23 "(ii) special education and related
24 services provided under the Individuals
25 with Disabilities Education Act and voca-

1 tional rehabilitation services provided
2 under the Rehabilitation Act of 1973;
3 "(iii) assistive technology devices and
4 assistive technology services other than
5 those under (1)(B)(ii);
6 "(iv) medical supplies and equipment;
7 or
8 "(v) home modifications.
9 "(D) PERMISSIBLE SERVICES AND SUP-
10 PORTS.—The home and community-based at-
11 tendant services and supports may include—
12 "(i) expenditures for transition costs
13 such as rent and utility deposits, first
14 month's rent and utilities, bedding, basic
15 kitchen supplies, and other necessities re-
16 quired for an individual to make the tran-
17 sition from a nursing facility, institution
18 for mental diseases, or intermediate care
19 facility for the mentally retarded to a com-
20 munity-based home setting where the indi-
21 vidual resides; and
22 "(ii) expenditures relating to a need
23 identified in an individual's person-cen-
24 tered plan of services that increase inde-
25 pendence or substitute for human assist-

ance, to the extent that expenditures would otherwise be made for the human assistance.

"(2) INCREASED FEDERAL FINANCIAL PARTICIPATION.—For purposes of payments to a State under section 1903(a)(1), with respect to amounts expended by the State to provide medical assistance under the State plan for home and community-based attendant services and supports to eligible individuals in accordance with this subsection during a fiscal year quarter occurring during the period described in paragraph (1), the Federal medical assistance percentage applicable to the State (as determined under section 1905(b)) shall be increased by 6 percentage points.

"(3) STATE REQUIREMENTS.—In order for a State plan amendment to be approved under this subsection, the State shall—

"(A) develop and implement such amendment in collaboration with a Development and Implementation Council established by the State that includes a majority of members with disabilities, elderly individuals, and their representatives and consults and collaborates with such individuals;

1 "(B) provide consumer controlled home
2 and community-based attendant services and
3 supports to individuals on a statewide basis, in
4 a manner that provides such services and sup-
5 ports in the most integrated setting appropriate
6 to the individual's needs, and without regard to
7 the individual's age, type or nature of disability,
8 severity of disability, or the form of home and
9 community-based attendant services and sup-
10 ports that the individual requires in order to
11 lead an independent life;
12 "(C) with respect to expenditures during
13 the first full fiscal year in which the State plan
14 amendment is implemented, maintain or exceed
15 the level of State expenditures for medical as-
16 sistance that is provided under section 1905(a),
17 section 1915, section 1115, or otherwise to indi-
18 viduals with disabilities or elderly individuals
19 attributable to the preceding fiscal year;
20 "(D) establish and maintain a comprehen-
21 sive, continuous quality assurance system with
22 respect to community- based attendant services
23 and supports that—
24 "(i) includes standards for agency-
25 based and other delivery models with re-

1 spect to training, appeals for denials and
2 reconsideration procedures of an individual
3 plan, and other factors as determined by
4 the Secretary;
5 ''(ii) incorporates feedback from con-
6 sumers and their representatives, disability
7 organizations, providers, families of dis-
8 abled or elderly individuals, members of
9 the community, and others and maximizes
10 consumer independence and consumer con-
11 trol;
12 ''(iii) monitors the health and well-
13 being of each individual who receives home
14 and community-based attendant services
15 and supports, including a process for the
16 mandatory reporting, investigation, and
17 resolution of allegations of neglect, abuse,
18 or exploitation in connection with the pro-
19 vision of such services and supports; and
20 ''(iv) provides information about the
21 provisions of the quality assurance re-
22 quired under clauses (i) through (iii) to
23 each individual receiving such services; and
24 ''(E) collect and report information, as de-
25 termined necessary by the Secretary, for the

1 purposes of approving the State plan amend-
2 ment, providing Federal oversight, and con-
3 ducting an evaluation under paragraph (5)(A),
4 including data regarding how the State provides
5 home and community-based attendant services
6 and supports and other home and community-
7 based services, the cost of such services and
8 supports, and how the State provides individ-
9 uals with disabilities who otherwise qualify for
10 institutional care under the State plan or under
11 a waiver the choice to instead receive home and
12 community-based services in lieu of institutional
13 care.

14 "(4) COMPLIANCE WITH CERTAIN LAWS.—A
15 State shall ensure that, regardless of whether the
16 State uses an agency-provider model or other models
17 to provide home and community-based attendant
18 services and supports under a State plan amend-
19 ment under this subsection, such services and sup-
20 ports are provided in accordance with the require-
21 ments of the Fair Labor Standards Act of 1938 and
22 applicable Federal and State laws regarding—

23 "(A) withholding and payment of Federal
24 and State income and payroll taxes;

1 "(B) the provision of unemployment and
2 workers compensation insurance;
3 "(C) maintenance of general liability insur-
4 ance; and
5 "(D) occupational health and safety.
6 "(5) EVALUATION, DATA COLLECTION, AND RE-
7 PORT TO CONGRESS.—
8 "(A) EVALUATION.—The Secretary shall
9 conduct an evaluation of the provision of home
10 and community-based attendant services and
11 supports under this subsection in order to de-
12 termine the effectiveness of the provision of
13 such services and supports in allowing the indi-
14 viduals receiving such services and supports to
15 lead an independent life to the maximum extent
16 possible; the impact on the physical and emo-
17 tional health of the individuals who receive such
18 services; and an comparative analysis of the
19 costs of services provided under the State plan
20 amendment under this subsection and those
21 provided under institutional care in a nursing
22 facility, institution for mental diseases, or an
23 intermediate care facility for the mentally re-
24 tarded.

"(B) DATA COLLECTION.—The State shall provide the Secretary with the following information regarding the provision of home and community-based attendant services and supports under this subsection for each fiscal year for which such services and supports are provided:

"(i) The number of individuals who are estimated to receive home and community-based attendant services and supports under this subsection during the fiscal year.

"(ii) The number of individuals that received such services and supports during the preceding fiscal year.

"(iii) The specific number of individuals served by type of disability, age, gender, education level, and employment status.

"(iv) Whether the specific individuals have been previously served under any other home and community based services program under the State plan or under a waiver.

"(C) REPORTS.—Not later than—

"(i) December 31, 2013, the Secretary shall submit to Congress and make available to the public an interim report on the findings of the evaluation under subparagraph (A); and

"(ii) December 31, 2015, the Secretary shall submit to Congress and make available to the public a final report on the findings of the evaluation under subparagraph (A).

"(6) DEFINITIONS.—In this subsection:

"(A) ACTIVITIES OF DAILY LIVING.—The term 'activities of daily living' includes tasks such as eating, toileting, grooming, dressing, bathing, and transferring.

"(B) CONSUMER CONTROLLED.—The term 'consumer controlled' means a method of selecting and providing services and supports that allow the individual, or where appropriate, the individual's representative, maximum control of the home and community-based attendant services and supports, regardless of who acts as the employer of record.

"(C) DELIVERY MODELS.—

1 "(i) AGENCY-PROVIDER MODEL.—The
2 term 'agency-provider model' means, with
3 respect to the provision of home and com-
4 munity-based attendant services and sup-
5 ports for an individual, subject to para-
6 graph (4), a method of providing consumer
7 controlled services and supports under
8 which entities contract for the provision of
9 such services and supports.
10 "(ii) OTHER MODELS.—The term
11 'other models' means, subject to paragraph
12 (4), methods, other than an agency-pro-
13 vider model, for the provision of consumer
14 controlled services and supports. Such
15 models may include the provision of vouch-
16 ers, direct cash payments, or use of a fiscal
17 agent to assist in obtaining services.
18 "(D) HEALTH-RELATED TASKS.—The
19 term 'health-related tasks' means specific tasks
20 related to the needs of an individual, which can
21 be delegated or assigned by licensed health-care
22 professionals under State law to be performed
23 by an attendant.
24 "(E) INDIVIDUAL'S REPRESENTATIVE.—
25 The term 'individual's representative' means a

parent, family member, guardian, advocate, or other authorized representative of an individual

"(F) INSTRUMENTAL ACTIVITIES OF DAILY LIVING.—The term 'instrumental activities of daily living' includes (but is not limited to) meal planning and preparation, managing finances, shopping for food, clothing, and other essential items, performing essential household chores, communicating by phone or other media, and traveling around and participating in the community.".

SEC. 2402. REMOVAL OF BARRIERS TO PROVIDING HOME AND COMMUNITY-BASED SERVICES.

(a) OVERSIGHT AND ASSESSMENT OF THE ADMINISTRATION OF HOME AND COMMUNITY-BASED SERVICES.—The Secretary of Health and Human Services shall promulgate regulations to ensure that all States develop service systems that are designed to—

(1) allocate resources for services in a manner that is responsive to the changing needs and choices of beneficiaries receiving non-institutionally-based long-term services and supports (including such services and supports that are provided under programs other the State Medicaid program), and that provides strategies for beneficiaries receiving such

1 services to maximize their independence, including
2 through the use of client-employed providers;
3 (2) provide the support and coordination needed
4 for a beneficiary in need of such services (and their
5 family caregivers or representative, if applicable) to
6 design an individualized, self-directed, community-
7 supported life; and
8 (3) improve coordination among, and the regu-
9 lation of, all providers of such services under feder-
10 ally and State-funded programs in order to—
11 (A) achieve a more consistent administra-
12 tion of policies and procedures across programs
13 in relation to the provision of such services; and
14 (B) oversee and monitor all service system
15 functions to assure—
16 (i) coordination of, and effectiveness
17 of, eligibility determinations and individual
18 assessments;
19 (ii) development and service moni-
20 toring of a complaint system, a manage-
21 ment system, a system to qualify and mon-
22 itor providers, and systems for role-setting
23 and individual budget determinations; and

(iii) an adequate number of qualified direct care workers to provide self-directed personal assistance services.

(b) ADDITIONAL STATE OPTIONS.—Section 1915(i) of the Social Security Act (42 U.S.C. 1396n(i)) is amended by adding at the end the following new paragraphs:

"(6) STATE OPTION TO PROVIDE HOME AND COMMUNITY-BASED SERVICES TO INDIVIDUALS ELIGIBLE FOR SERVICES UNDER A WAIVER.—

"(A) IN GENERAL.—A State that provides home and community-based services in accordance with this subsection to individuals who satisfy the needs-based criteria for the receipt of such services established under paragraph (1)(A) may, in addition to continuing to provide such services to such individuals, elect to provide home and community-based services in accordance with the requirements of this paragraph to individuals who are eligible for home and community-based services under a waiver approved for the State under subsection (c), (d), or (e) or under section 1115 to provide such services, but only for those individuals whose income does not exceed 300 percent of

the supplemental security income benefit rate established by section 1611(b)(1).

"(B) APPLICATION OF SAME REQUIREMENTS FOR INDIVIDUALS SATISFYING NEEDS-BASED CRITERIA.—Subject to subparagraph (C), a State shall provide home and community-based services to individuals under this paragraph in the same manner and subject to the same requirements as apply under the other paragraphs of this subsection to the provision of home and community-based services to individuals who satisfy the needs-based criteria established under paragraph (1)(A).

"(C) AUTHORITY TO OFFER DIFFERENT TYPE, AMOUNT, DURATION, OR SCOPE OF HOME AND COMMUNITY-BASED SERVICES.—A State may offer home and community-based services to individuals under this paragraph that differ in type, amount, duration, or scope from the home and community-based services offered for individuals who satisfy the needs-based criteria established under paragraph (1)(A), so long as such services are within the scope of services described in paragraph (4)(B) of subsection (c) for which the Secretary has the authority to ap-

prove a waiver and do not include room or board.

"(7) STATE OPTION TO OFFER HOME AND COMMUNITY-BASED SERVICES TO SPECIFIC, TARGETED POPULATIONS.—

"(A) IN GENERAL.—A State may elect in a State plan amendment under this subsection to target the provision of home and community-based services under this subsection to specific populations and to differ the type, amount, duration, or scope of such services to such specific populations.

"(B) 5-YEAR TERM.—

"(i) IN GENERAL.—An election by a State under this paragraph shall be for a period of 5 years.

"(ii) PHASE-IN OF SERVICES AND ELIGIBILITY PERMITTED DURING INITIAL 5-YEAR PERIOD.—A State making an election under this paragraph may, during the first 5-year period for which the election is made, phase-in the enrollment of eligible individuals, or the provision of services to such individuals, or both, so long as all eligible individuals in the State for such serv-

ices are enrolled, and all such services are provided, before the end of the initial 5-year period.

"(C) RENEWAL.—An election by a State under this paragraph may be renewed for additional 5-year terms if the Secretary determines, prior to beginning of each such renewal period, that the State has—

"(i) adhered to the requirements of this subsection and paragraph in providing services under such an election; and

"(ii) met the State's objectives with respect to quality improvement and beneficiary outcomes.".

(c) REMOVAL OF LIMITATION ON SCOPE OF SERVICES.—Paragraph (1) of section 1915(i) of the Social Security Act (42 U.S.C. 1396n(i)), as amended by subsection (a), is amended by striking "or such other services requested by the State as the Secretary may approve".

(d) OPTIONAL ELIGIBILITY CATEGORY TO PROVIDE FULL MEDICAID BENEFITS TO INDIVIDUALS RECEIVING HOME AND COMMUNITY-BASED SERVICES UNDER A STATE PLAN AMENDMENT.—

(1) IN GENERAL.—Section 1902(a)(10)(A)(ii) of the Social Security Act (42 U.S.C.

1396a(a)(10)(A)(ii)), as amended by section 2304(a)(1), is amended—

(A) in subclause (XX), by striking ''or'' at the end;

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

(C) by inserting after subclause (XXI), the following new subclause:

''(XXII) who are eligible for home and community-based services under needs-based criteria established under paragraph (1)(A) of section 1915(i), or who are eligible for home and community-based services under paragraph (6) of such section, and who will receive home and community-based services pursuant to a State plan amendment under such subsection;''.

(2) CONFORMING AMENDMENTS.—

(A) Section 1903(f)(4) of the Social Security Act (42 U.S.C. 1396b(f)(4)), as amended by section 2304(a)(4)(B), is amended in the matter preceding subparagraph (A), by insert-

ing "1902(a)(10)(A)(ii)(XXII)," after "1902(a)(10)(A)(ii)(XXI),".

(B) Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)), as so amended, is amended in the matter preceding paragraph (1)—

(i) in clause (xv), by striking "or" at the end;

(ii) in clause (xvi), by adding "or" at the end; and

(iii) by inserting after clause (xvi) the following new clause:

"(xvii) individuals who are eligible for home and community-based services under needs-based criteria established under paragraph (1)(A) of section 1915(i), or who are eligible for home and community-based services under paragraph (6) of such section, and who will receive home and community-based services pursuant to a State plan amendment under such subsection,".

(e) ELIMINATION OF OPTION TO LIMIT NUMBER OF ELIGIBLE INDIVIDUALS OR LENGTH OF PERIOD FOR GRANDFATHERED INDIVIDUALS IF ELIGIBILITY CRITERIA IS MODIFIED.—Paragraph (1) of section 1915(i) of such Act (42 U.S.C. 1396n(i)) is amended—

(1) by striking subparagraph (C) and inserting the following:

"(C) PROJECTION OF NUMBER OF INDIVIDUALS TO BE PROVIDED HOME AND COMMUNITY-BASED SERVICES.—The State submits to the Secretary, in such form and manner, and upon such frequency as the Secretary shall specify, the projected number of individuals to be provided home and community-based services."; and

(2) in subclause (II) of subparagraph (D)(ii), by striking "to be eligible for such services for a period of at least 12 months beginning on the date the individual first received medical assistance for such services" and inserting "to continue to be eligible for such services after the effective date of the modification and until such time as the individual no longer meets the standard for receipt of such services under such pre-modified criteria".

(f) ELIMINATION OF OPTION TO WAIVE STATEWIDENESS; ADDITION OF OPTION TO WAIVE COMPARABILITY.—Paragraph (3) of section 1915(i) of such Act (42 U.S.C. 1396n(3)) is amended by striking "1902(a)(1) (relating to statewideness)" and inserting "1902(a)(10)(B) (relating to comparability)".

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

SEC. 2403. MONEY FOLLOWS THE PERSON REBALANCING DEMONSTRATION.

(a) EXTENSION OF DEMONSTRATION.—

(1) IN GENERAL.—Section 6071(h) of the Deficit Reduction Act of 2005 (42 U.S.C. 1396a note) is amended—

(A) in paragraph (1)(E), by striking ''fiscal year 2011'' and inserting ''each of fiscal years 2011 through 2016''; and

(B) in paragraph (2), by striking ''2011'' and inserting ''2016''.

(2) EVALUATION.—Paragraphs (2) and (3) of section 6071(g) of such Act is amended are each amended by striking ''2011'' and inserting ''2016''.

(b) REDUCTION OF INSTITUTIONAL RESIDENCY PERIOD.—

(1) IN GENERAL.—Section 6071(b)(2) of the Deficit Reduction Act of 2005 (42 U.S.C. 1396a note) is amended—

(A) in subparagraph (A)(i), by striking '', for a period of not less than 6 months or for

such longer minimum period, not to exceed 2 years, as may be specified by the State'' and inserting ''for a period of not less than 90 consecutive days''; and

(B) by adding at the end the following:

''Any days that an individual resides in an institution on the basis of having been admitted solely for purposes of receiving short-term rehabilitative services for a period for which payment for such services is limited under title XVIII shall not be taken into account for purposes of determining the 90-day period required under subparagraph (A)(i).''.

(2) EFFECTIVE DATE.—The amendments made by this subsection take effect 30 days after the date of enactment of this Act.

SEC. 2404. PROTECTION FOR RECIPIENTS OF HOME AND COMMUNITY-BASED SERVICES AGAINST SPOUSAL IMPOVERISHMENT.

During the 5-year period that begins on January 1, 2014, section 1924(h)(1)(A) of the Social Security Act (42 U.S.C. 1396r–5(h)(1)(A)) shall be applied as though ''is eligible for medical assistance for home and community-based services provided under subsection (c), (d), or (i) of section 1915, under a waiver approved under section 1115, or who is eligible for such medical assistance by rea-

son of being determined eligible under section 1902(a)(10)(C) or by reason of section 1902(f) or otherwise on the basis of a reduction of income based on costs incurred for medical or other remedial care, or who is eligible for medical assistance for home and community-based attendant services and supports under section 1915(k)'' were substituted in such section for ''(at the option of the State) is described in section 1902(a)(10)(A)(ii)(VI)''.

SEC. 2405. FUNDING TO EXPAND STATE AGING AND DISABILITY RESOURCE CENTERS.

Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Secretary of Health and Human Services, acting through the Assistant Secretary for Aging, $10,000,000 for each of fiscal years 2010 through 2014, to carry out subsections (a)(20)(B)(iii) and (b)(8) of section 202 of the Older Americans Act of 1965 (42 U.S.C. 3012).

SEC. 2406. SENSE OF THE SENATE REGARDING LONG-TERM CARE.

(a) FINDINGS.—The Senate makes the following findings:

(1) Nearly 2 decades have passed since Congress seriously considered long-term care reform. The United States Bipartisan Commission on Comprehensive Health Care, also know as the ''Pepper

1 Commission'', released its ''Call for Action'' blue-
2 print for health reform in September 1990. In the
3 20 years since those recommendations were made,
4 Congress has never acted on the report.
5 (2) In 1999, under the United States Supreme
6 Court's decision in *Olmstead v. L.C.,* 527 U.S. 581
7 (1999), individuals with disabilities have the right to
8 choose to receive their long-term services and sup-
9 ports in the community, rather than in an institu-
10 tional setting.
11 (3) Despite the Pepper Commission and
12 *Olmstead* decision, the long-term care provided to
13 our Nation's elderly and disabled has not improved.
14 In fact, for many, it has gotten far worse.
15 (4) In 2007, 69 percent of Medicaid long-term
16 care spending for elderly individuals and adults with
17 physical disabilities paid for institutional services.
18 Only 6 states spent 50 percent or more of their
19 Medicaid long-term care dollars on home and com-
20 munity-based services for elderly individuals and
21 adults with physical disabilities while ½ of the
22 States spent less than 25 percent. This disparity
23 continues even though, on average, it is estimated
24 that Medicaid dollars can support nearly 3 elderly
25 individuals and adults with physical disabilities in

home and community-based services for every individual in a nursing home. Although every State has chosen to provide certain services under home and community-based waivers, these services are unevenly available within and across States, and reach a small percentage of eligible individuals.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that—

(1) during the 111th session of Congress, Congress should address long-term services and supports in a comprehensive way that guarantees elderly and disabled individuals the care they need; and

(2) long term services and supports should be made available in the community in addition to in institutions.

Subtitle F—Medicaid Prescription Drug Coverage

SEC. 2501. PRESCRIPTION DRUG REBATES.

(a) INCREASE IN MINIMUM REBATE PERCENTAGE FOR SINGLE SOURCE DRUGS AND INNOVATOR MULTIPLE SOURCE DRUGS.—

(1) IN GENERAL.—Section 1927(c)(1)(B) of the Social Security Act (42 U.S.C. 1396r–8(c)(1)(B)) is amended—

(A) in clause (i)—

(i) in subclause (IV), by striking "and" at the end;

(ii) in subclause (V)—

(I) by inserting "and before January 1, 2010" after "December 31, 1995,"; and

(II) by striking the period at the end and inserting "; and"; and

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

"(VI) except as provided in clause (iii), after December 31, 2009, 23.1 percent."; and

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

"(iii) MINIMUM REBATE PERCENTAGE FOR CERTAIN DRUGS.—

"(I) IN GENERAL.—In the case of a single source drug or an innovator multiple source drug described in subclause (II), the minimum rebate percentage for rebate periods specified in clause (i)(VI) is 17.1 percent.

"(II) DRUG DESCRIBED.—For purposes of subclause (I), a single

source drug or an innovator multiple source drug described in this subclause is any of the following drugs:

"(aa) A clotting factor for which a separate furnishing payment is made under section 1842(o)(5) and which is included on a list of such factors specified and updated regularly by the Secretary.

"(bb) A drug approved by the Food and Drug Administration exclusively for pediatric indications.".

(2) RECAPTURE OF TOTAL SAVINGS DUE TO INCREASE.—Section 1927(b)(1) of such Act (42 U.S.C. 1396r–8(b)(1)) is amended by adding at the end the following new subparagraph:

"(C) SPECIAL RULE FOR INCREASED MINIMUM REBATE PERCENTAGE.—

"(i) IN GENERAL.—In addition to the amounts applied as a reduction under subparagraph (B), for rebate periods beginning on or after January 1, 2010, during a fiscal year, the Secretary shall reduce

payments to a State under section 1903(a) in the manner specified in clause (ii), in an amount equal to the product of—

"(I) 100 percent minus the Federal medical assistance percentage applicable to the rebate period for the State; and

"(II) the amounts received by the State under such subparagraph that are attributable (as estimated by the Secretary based on utilization and other data) to the increase in the minimum rebate percentage effected by the amendments made by subsections (a)(1), (b), and (d) of section 2501 of the Patient Protection and Affordable Care Act, taking into account the additional drugs included under the amendments made by subsection (c) of section 2501 of such Act.

The Secretary shall adjust such payment reduction for a calendar quarter to the extent the Secretary determines, based upon subsequent utilization and other data, that the reduction for such quarter was greater

or less than the amount of payment reduction that should have been made.

"(ii) MANNER OF PAYMENT REDUCTION.—The amount of the payment reduction under clause (i) for a State for a quarter shall be deemed an overpayment to the State under this title to be disallowed against the State's regular quarterly draw for all Medicaid spending under section 1903(d)(2). Such a disallowance is not subject to a reconsideration under section 1116(d).".

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

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

(2) in clause (ii)—

(A) by inserting "and before January 1, 2010," after "December 31, 1993,"; and

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

(3) by adding at the end the following new clause:

"(iii) after December 31, 2009, is 13 percent.".

1 (c) EXTENSION OF PRESCRIPTION DRUG DISCOUNTS
2 TO ENROLLEES OF MEDICAID MANAGED CARE ORGANI-
3 ZATIONS.—
4 (1) IN GENERAL.—Section 1903(m)(2)(A) of
5 such Act (42 U.S.C. 1396b(m)(2)(A)) is amended—
6 (A) in clause (xi), by striking ''and'' at the
7 end;
8 (B) in clause (xii), by striking the period
9 at the end and inserting ''; and''; and
10 (C) by adding at the end the following:
11 ''(xiii) such contract provides that (I)
12 covered outpatient drugs dispensed to indi-
13 viduals eligible for medical assistance who
14 are enrolled with the entity shall be subject
15 to the same rebate required by the agree-
16 ment entered into under section 1927 as
17 the State is subject to and that the State
18 shall collect such rebates from manufactur-
19 ers, (II) capitation rates paid to the entity
20 shall be based on actual cost experience re-
21 lated to rebates and subject to the Federal
22 regulations requiring actuarially sound
23 rates, and (III) the entity shall report to
24 the State, on such timely and periodic
25 basis as specified by the Secretary in order

to include in the information submitted by the State to a manufacturer and the Secretary under section 1927(b)(2)(A), information on the total number of units of each dosage form and strength and package size by National Drug Code of each covered outpatient drug dispensed to individuals eligible for medical assistance who are enrolled with the entity and for which the entity is responsible for coverage of such drug under this subsection (other than covered outpatient drugs that under subsection (j)(1) of section 1927 are not subject to the requirements of that section) and such other data as the Secretary determines necessary to carry out this subsection.''.

(2) CONFORMING AMENDMENTS.—Section 1927 (42 U.S.C. 1396r–8) is amended—

(A) in subsection (b)—

(i) in paragraph (1)(A), in the first sentence, by inserting '', including such drugs dispensed to individuals enrolled with a medicaid managed care organization if the organization is responsible for cov-

erage of such drugs'' before the period; and

(ii) in paragraph (2)(A), by inserting ''including such information reported by each medicaid managed care organization,'' after ''for which payment was made under the plan during the period,''; and

(B) in subsection (j), by striking paragraph (1) and inserting the following:

''(1) Covered outpatient drugs are not subject to the requirements of this section if such drugs are—

''(A) dispensed by health maintenance organizations, including Medicaid managed care organizations that contract under section 1903(m); and

''(B) subject to discounts under section 340B of the Public Health Service Act.''.

(d) ADDITIONAL REBATE FOR NEW FORMULATIONS OF EXISTING DRUGS.—

(1) IN GENERAL.—Section 1927(c)(2) of the Social Security Act (42 U.S.C. 1396r–8(c)(2)) is amended by adding at the end the following new subparagraph:

1 "(C) TREATMENT OF NEW FORMULA-
2 TIONS.—
3 "(i) IN GENERAL.—Except as pro-
4 vided in clause (ii), in the case of a drug
5 that is a new formulation, such as an ex-
6 tended-release formulation, of a single
7 source drug or an innovator multiple
8 source drug, the rebate obligation with re-
9 spect to the drug under this section shall
10 be the amount computed under this section
11 for the new formulation of the drug or, if
12 greater, the product of—
13 "(I) the average manufacturer
14 price for each dosage form and
15 strength of the new formulation of the
16 single source drug or innovator mul-
17 tiple source drug;
18 "(II) the highest additional re-
19 bate (calculated as a percentage of av-
20 erage manufacturer price) under this
21 section for any strength of the origi-
22 nal single source drug or innovator
23 multiple source drug; and
24 "(III) the total number of units
25 of each dosage form and strength of

the new formulation paid for under the State plan in the rebate period (as reported by the State).

"(ii) NO APPLICATION TO NEW FORMULATIONS OF ORPHAN DRUGS.—Clause (i) shall not apply to a new formulation of a covered outpatient drug that is or has been designated under section 526 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bb) for a rare disease or condition, without regard to whether the period of market exclusivity for the drug under section 527 of such Act has expired or the specific indication for use of the drug.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to drugs that are paid for by a State after December 31, 2009.

(e) MAXIMUM REBATE AMOUNT.—Section 1927(c)(2) of such Act (42 U.S.C. 1396r–8(c)(2)), as amended by subsection (d), is amended by adding at the end the following new subparagraph:

"(D) MAXIMUM REBATE AMOUNT.—In no case shall the sum of the amounts applied under paragraph (1)(A)(ii) and this paragraph with respect to each dosage form and strength

of a single source drug or an innovator multiple source drug for a rebate period beginning after December 31, 2009, exceed 100 percent of the average manufacturer price of the drug.''.

(f) CONFORMING AMENDMENTS.—

(1) IN GENERAL.—Section 340B of the Public Health Service Act (42 U.S.C. 256b) is amended—

(A) in subsection (a)(2)(B)(i), by striking ''1927(c)(4)'' and inserting ''1927(c)(3)''; and

(B) by striking subsection (c); and

(C) redesignating subsection (d) as subsection (c).

(2) EFFECTIVE DATE.—The amendments made by this subsection take effect on January 1, 2010.

SEC. 2502. ELIMINATION OF EXCLUSION OF COVERAGE OF CERTAIN DRUGS.

(a) IN GENERAL.—Section 1927(d) of the Social Security Act (42 U.S.C. 1397r–8(d)) is amended—

(1) in paragraph (2)—

(A) by striking subparagraphs (E), (I), and (J), respectively; and

(B) by redesignating subparagraphs (F), (G), (H), and (K) as subparagraphs (E), (F), (G), and (H), respectively; and

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

"(7) NON-EXCLUDABLE DRUGS.—The following drugs or classes of drugs, or their medical uses, shall not be excluded from coverage:

"(A) Agents when used to promote smoking cessation, including agents approved by the Food and Drug Administration under the over-the-counter monograph process for purposes of promoting, and when used to promote, tobacco cessation.

"(B) Barbiturates.

"(C) Benzodiazepines.".

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2014.

SEC. 2503. PROVIDING ADEQUATE PHARMACY REIMBURSEMENT.

(a) PHARMACY REIMBURSEMENT LIMITS.—

(1) IN GENERAL.—Section 1927(e) of the Social Security Act (42 U.S.C. 1396r–8(e)) is amended—

(A) in paragraph (4), by striking "(or, effective January 1, 2007, two or more)"; and

(B) by striking paragraph (5) and inserting the following:

''(5) USE OF AMP IN UPPER PAYMENT LIMITS.—The Secretary shall calculate the Federal upper reimbursement limit established under paragraph (4) as no less than 175 percent of the weighted average (determined on the basis of utilization) of the most recently reported monthly average manufacturer prices for pharmaceutically and therapeutically equivalent multiple source drug products that are available for purchase by retail community pharmacies on a nationwide basis. The Secretary shall implement a smoothing process for average manufacturer prices. Such process shall be similar to the smoothing process used in determining the average sales price of a drug or biological under section 1847A.''.

(2) DEFINITION OF AMP.—Section 1927(k)(1) of such Act (42 U.S.C. 1396r–8(k)(1)) is amended—

(A) in subparagraph (A), by striking ''by'' and all that follows through the period and inserting ''by—

''(i) wholesalers for drugs distributed to retail community pharmacies; and

1 "(ii) retail community pharmacies
2 that purchase drugs directly from the man-
3 ufacturer."; and
4 (B) by striking subparagraph (B) and in-
5 serting the following:
6 "(B) EXCLUSION OF CUSTOMARY PROMPT
7 PAY DISCOUNTS AND OTHER PAYMENTS.—
8 "(i) IN GENERAL.—The average man-
9 ufacturer price for a covered outpatient
10 drug shall exclude—
11 "(I) customary prompt pay dis-
12 counts extended to wholesalers;
13 "(II) bona fide service fees paid
14 by manufacturers to wholesalers or re-
15 tail community pharmacies, including
16 (but not limited to) distribution serv-
17 ice fees, inventory management fees,
18 product stocking allowances, and fees
19 associated with administrative services
20 agreements and patient care programs
21 (such as medication compliance pro-
22 grams and patient education pro-
23 grams);
24 "(III) reimbursement by manu-
25 facturers for recalled, damaged, ex-

1 pired, or otherwise unsalable returned
2 goods, including (but not limited to)
3 reimbursement for the cost of the
4 goods and any reimbursement of costs
5 associated with return goods handling
6 and processing, reverse logistics, and
7 drug destruction; and
8 "(IV) payments received from,
9 and rebates or discounts provided to,
10 pharmacy benefit managers, managed
11 care organizations, health mainte-
12 nance organizations, insurers, hos-
13 pitals, clinics, mail order pharmacies,
14 long term care providers, manufactur-
15 ers, or any other entity that does not
16 conduct business as a wholesaler or a
17 retail community pharmacy.
18 "(ii) INCLUSION OF OTHER DIS-
19 COUNTS AND PAYMENTS.—Notwith-
20 standing clause (i), any other discounts,
21 rebates, payments, or other financial trans-
22 actions that are received by, paid by, or
23 passed through to, retail community phar-
24 macies shall be included in the average

manufacturer price for a covered outpatient drug.''; and

(C) in subparagraph (C), by striking ''the retail pharmacy class of trade'' and inserting ''retail community pharmacies''.

(3) DEFINITION OF MULTIPLE SOURCE DRUG.—Section 1927(k)(7) of such Act (42 U.S.C. 1396r–8(k)(7)) is amended—

(A) in subparagraph (A)(i)(III), by striking ''the State'' and inserting ''the United States''; and

(B) in subparagraph (C)—

(i) in clause (i), by inserting ''and'' after the semicolon;

(ii) in clause (ii), by striking ''; and'' and inserting a period; and

(iii) by striking clause (iii).

(4) DEFINITIONS OF RETAIL COMMUNITY PHARMACY; WHOLESALER.—Section 1927(k) of such Act (42 U.S.C. 1396r–8(k)) is amended by adding at the end the following new paragraphs:

''(10) RETAIL COMMUNITY PHARMACY.—The term 'retail community pharmacy' means an independent pharmacy, a chain pharmacy, a supermarket pharmacy, or a mass merchandiser phar-

1 macy that is licensed as a pharmacy by the State
2 and that dispenses medications to the general public
3 at retail prices. Such term does not include a phar-
4 macy that dispenses prescription medications to pa-
5 tients primarily through the mail, nursing home
6 pharmacies, long-term care facility pharmacies, hos-
7 pital pharmacies, clinics, charitable or not-for-profit
8 pharmacies, government pharmacies, or pharmacy
9 benefit managers.

10 ''(11) WHOLESALER.—The term 'wholesaler'
11 means a drug wholesaler that is engaged in whole-
12 sale distribution of prescription drugs to retail com-
13 munity pharmacies, including (but not limited to)
14 manufacturers, repackers, distributors, own-label
15 distributors, private-label distributors, jobbers, bro-
16 kers, warehouses (including manufacturer's and dis-
17 tributor's warehouses, chain drug warehouses, and
18 wholesale drug warehouses) independent wholesale
19 drug traders, and retail community pharmacies that
20 conduct wholesale distributions.''.

21 (b) DISCLOSURE OF PRICE INFORMATION TO THE
22 PUBLIC.—Section 1927(b)(3) of such Act (42 U.S.C.
23 1396r–8(b)(3)) is amended—

24 (1) in subparagraph (A)—

(A) in the first sentence, by inserting after clause (iii) the following:

"(iv) not later than 30 days after the last day of each month of a rebate period under the agreement, on the manufacturer's total number of units that are used to calculate the monthly average manufacturer price for each covered outpatient drug;"; and

(B) in the second sentence, by inserting "(relating to the weighted average of the most recently reported monthly average manufacturer prices)" after "(D)(v)"; and

(2) in subparagraph (D)(v), by striking "average manufacturer prices" and inserting "the weighted average of the most recently reported monthly average manufacturer prices and the average retail survey price determined for each multiple source drug in accordance with subsection (f)".

(c) CLARIFICATION OF APPLICATION OF SURVEY OF RETAIL PRICES.—Section 1927(f)(1) of such Act (42 U.S.C. 1396r–8(b)(1)) is amended—

(1) in subparagraph (A)(i), by inserting "with respect to a retail community pharmacy," before "the determination"; and

(2) in subparagraph (C)(ii), by striking ''retail pharmacies'' and inserting ''retail community pharmacies''.

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on the first day of the first calendar year quarter that begins at least 180 days after the date of enactment of this Act, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

Subtitle G—Medicaid Disproportionate Share Hospital (DSH) Payments

SEC. 2551. DISPROPORTIONATE SHARE HOSPITAL PAYMENTS.

(a) IN GENERAL.—Section 1923(f) of the Social Security Act (42 U.S.C. 1396r–4(f)) is amended—

(1) in paragraph (1), by striking ''and (3)'' and inserting '', (3), and (7)'';

(2) in paragraph (3)(A), by striking ''paragraph (6)'' and inserting ''paragraphs (6) and (7)'';

(3) by redesignating paragraph (7) as paragraph (8); and

(4) by inserting after paragraph (6) the following new paragraph:

"(7) REDUCTION OF STATE DSH ALLOTMENTS ONCE REDUCTION IN UNINSURED THRESHOLD REACHED.—

"(A) IN GENERAL.—Subject to subparagraph (E), the DSH allotment for a State for fiscal years beginning with the fiscal year described in subparagraph (C) (with respect to the State), is equal to—

"(i) in the case of the first fiscal year described in subparagraph (C) with respect to a State, the DSH allotment that would be determined under this subsection for the State for the fiscal year without application of this paragraph (but after the application of subparagraph (D)), reduced by the applicable percentage determined for the State for the fiscal year under subparagraph (B)(i); and

"(ii) in the case of any subsequent fiscal year with respect to the State, the DSH allotment determined under this paragraph for the State for the preceding fiscal year, reduced by the applicable percentage determined for the State for the fiscal year under subparagraph (B)(ii).

"(B) APPLICABLE PERCENTAGE.—For purposes of subparagraph (A), the applicable percentage for a State for a fiscal year is the following:

"(i) UNINSURED REDUCTION THRESHOLD FISCAL YEAR.—In the case of the first fiscal year described in subparagraph (C) with respect to the State—

"(I) if the State is a low DSH State described in paragraph (5)(B), the applicable percentage is equal to 25 percent; and

"(II) if the State is any other State, the applicable percentage is 50 percent.

"(ii) SUBSEQUENT FISCAL YEARS IN WHICH THE PERCENTAGE OF UNINSURED DECREASES.—In the case of any fiscal year after the first fiscal year described in subparagraph (C) with respect to a State, if the Secretary determines on the basis of the most recent American Community Survey of the Bureau of the Census, that the percentage of uncovered individuals residing in the State is less than the percentage

of such individuals determined for the State for the preceding fiscal year—

"(I) if the State is a low DSH State described in paragraph (5)(B), the applicable percentage is equal to the product of the percentage reduction in uncovered individuals for the fiscal year from the preceding fiscal year and 25 percent; and

"(II) if the State is any other State, the applicable percentage is equal to the product of the percentage reduction in uncovered individuals for the fiscal year from the preceding fiscal year and 50 percent.

"(C) FISCAL YEAR DESCRIBED.—For purposes of subparagraph (A), the fiscal year described in this subparagraph with respect to a State is the first fiscal year that occurs after fiscal year 2012 for which the Secretary determines, on the basis of the most recent American Community Survey of the Bureau of the Census, that the percentage of uncovered individuals residing in the State is at least 45 percent less than the percentage of such individ-

uals determined for the State for fiscal year 2009.

"(D) EXCLUSION OF PORTIONS DIVERTED FOR COVERAGE EXPANSIONS.—For purposes of applying the applicable percentage reduction under subparagraph (A) to the DSH allotment for a State for a fiscal year, the DSH allotment for a State that would be determined under this subsection for the State for the fiscal year without the application of this paragraph (and prior to any such reduction) shall not include any portion of the allotment for which the Secretary has approved the State's diversion to the costs of providing medical assistance or other health benefits coverage under a waiver that is in effect on July 2009.

"(E) MINIMUM ALLOTMENT.—In no event shall the DSH allotment determined for a State in accordance with this paragraph for fiscal year 2013 or any succeeding fiscal year be less than the amount equal to 35 percent of the DSH allotment determined for the State for fiscal year 2012 under this subsection (and after the application of this paragraph, if applicable), increased by the percentage change in the con-

sumer price index for all urban consumers (all items, U.S. city average) for each previous fiscal year occurring before the fiscal year.

"(F) UNCOVERED INDIVIDUALS.—In this paragraph, the term 'uncovered individuals' means individuals with no health insurance coverage at any time during a year (as determined by the Secretary based on the most recent data available).".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) take effect on October 1, 2011.

Subtitle H—Improved Coordination for Dual Eligible Beneficiaries

SEC. 2601. 5-YEAR PERIOD FOR DEMONSTRATION PROJECTS.

(a) IN GENERAL.—Section 1915(h) of the Social Security Act (42 U.S.C. 1396n(h)) is amended—

(1) by inserting "(1)" after "(h)";

(2) by inserting ", or a waiver described in paragraph (2)" after "(e)"; and

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

"(2)(A) Notwithstanding subsections (c)(3) and (d)(3), any waiver under subsection (b), (c), or (d), or a waiv-

1 er under section 1115, that provides medical assistance
2 for dual eligible individuals (including any such waivers
3 under which non dual eligible individuals may be enrolled
4 in addition to dual eligible individuals) may be conducted
5 for a period of 5 years and, upon the request of the State,
6 may be extended for additional 5-year periods unless the
7 Secretary determines that for the previous waiver period
8 the conditions for the waiver have not been met or it would
9 no longer be cost-effective and efficient, or consistent with
10 the purposes of this title, to extend the waiver.

11 ''(B) In this paragraph, the term 'dual eligible indi-
12 vidual' means an individual who is entitled to, or enrolled
13 for, benefits under part A of title XVIII, or enrolled for
14 benefits under part B of title XVIII, and is eligible for
15 medical assistance under the State plan under this title
16 or under a waiver of such plan.''.

17 (b) CONFORMING AMENDMENTS.—

18 (1) Section 1915 of such Act (42 U.S.C.
19 1396n) is amended—

20 (A) in subsection (b), by adding at the end
21 the following new sentence: ''Subsection (h)(2)
22 shall apply to a waiver under this subsection.'';

23 (B) in subsection (c)(3), in the second sen-
24 tence, by inserting ''(other than a waiver de-

scribed in subsection (h)(2))'' after ''A waiver under this subsection'';

(C) in subsection (d)(3), in the second sentence, by inserting ''(other than a waiver described in subsection (h)(2))'' after ''A waiver under this subsection''.

(2) Section 1115 of such Act (42 U.S.C. 1315) is amended—

(A) in subsection (e)(2), by inserting ''(5 years, in the case of a waiver described in section 1915(h)(2))'' after ''3 years''; and

(B) in subsection (f)(6), by inserting ''(5 years, in the case of a waiver described in section 1915(h)(2))'' after ''3 years''.

SEC. 2602. PROVIDING FEDERAL COVERAGE AND PAYMENT COORDINATION FOR DUAL ELIGIBLE BENEFICIARIES.

(a) ESTABLISHMENT OF FEDERAL COORDINATED HEALTH CARE OFFICE.—

(1) IN GENERAL.—Not later than March 1, 2010, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish a Federal Coordinated Health Care Office.

1 (2) ESTABLISHMENT AND REPORTING TO CMS
2 ADMINISTRATOR.—The Federal Coordinated Health
3 Care Office—
4 (A) shall be established within the Centers
5 for Medicare & Medicaid Services; and
6 (B) have as the Office a Director who shall
7 be appointed by, and be in direct line of author-
8 ity to, the Administrator of the Centers for
9 Medicare & Medicaid Services.
10 (b) PURPOSE.—The purpose of the Federal Coordi-
11 nated Health Care Office is to bring together officers and
12 employees of the Medicare and Medicaid programs at the
13 Centers for Medicare & Medicaid Services in order to—
14 (1) more effectively integrate benefits under the
15 Medicare program under title XVIII of the Social
16 Security Act and the Medicaid program under title
17 XIX of such Act; and
18 (2) improve the coordination between the Fed-
19 eral Government and States for individuals eligible
20 for benefits under both such programs in order to
21 ensure that such individuals get full access to the
22 items and services to which they are entitled under
23 titles XVIII and XIX of the Social Security Act.
24 (c) GOALS.—The goals of the Federal Coordinated
25 Health Care Office are as follows:

1 (1) Providing dual eligible individuals full ac-
2 cess to the benefits to which such individuals are en-
3 titled under the Medicare and Medicaid programs.
4 (2) Simplifying the processes for dual eligible
5 individuals to access the items and services they are
6 entitled to under the Medicare and Medicaid pro-
7 grams.
8 (3) Improving the quality of health care and
9 long-term services for dual eligible individuals.
10 (4) Increasing dual eligible individuals' under-
11 standing of and satisfaction with coverage under the
12 Medicare and Medicaid programs.
13 (5) Eliminating regulatory conflicts between
14 rules under the Medicare and Medicaid programs.
15 (6) Improving care continuity and ensuring safe
16 and effective care transitions for dual eligible indi-
17 viduals.
18 (7) Eliminating cost-shifting between the Medi-
19 care and Medicaid program and among related
20 health care providers.
21 (8) Improving the quality of performance of
22 providers of services and suppliers under the Medi-
23 care and Medicaid programs.

1 (d) SPECIFIC RESPONSIBILITIES.—The specific re-
2 sponsibilities of the Federal Coordinated Health Care Of-
3 fice are as follows:
4 (1) Providing States, specialized MA plans for
5 special needs individuals (as defined in section
6 1859(b)(6) of the Social Security Act (42 U.S.C.
7 1395w–28(b)(6))), physicians and other relevant en-
8 tities or individuals with the education and tools nec-
9 essary for developing programs that align benefits
10 under the Medicare and Medicaid programs for dual
11 eligible individuals.
12 (2) Supporting State efforts to coordinate and
13 align acute care and long-term care services for dual
14 eligible individuals with other items and services fur-
15 nished under the Medicare program.
16 (3) Providing support for coordination of con-
17 tracting and oversight by States and the Centers for
18 Medicare & Medicaid Services with respect to the in-
19 tegration of the Medicare and Medicaid programs in
20 a manner that is supportive of the goals described
21 in paragraph (3).
22 (4) To consult and coordinate with the Medi-
23 care Payment Advisory Commission established
24 under section 1805 of the Social Security Act (42
25 U.S.C. 1395b–6) and the Medicaid and CHIP Pay-

1 ment and Access Commission established under sec-
2 tion 1900 of such Act (42 U.S.C. 1396) with respect
3 to policies relating to the enrollment in, and provi-
4 sion of, benefits to dual eligible individuals under the
5 Medicare program under title XVIII of the Social
6 Security Act and the Medicaid program under title
7 XIX of such Act.

8 (5) To study the provision of drug coverage for
9 new full-benefit dual eligible individuals (as defined
10 in section 1935(c)(6) of the Social Security Act (42
11 U.S.C. 1396u–5(c)(6)), as well as to monitor and re-
12 port annual total expenditures, health outcomes, and
13 access to benefits for all dual eligible individuals.

14 (e) REPORT.—The Secretary shall, as part of the
15 budget transmitted under section 1105(a) of title 31,
16 United States Code, submit to Congress an annual report
17 containing recommendations for legislation that would im-
18 prove care coordination and benefits for dual eligible indi-
19 viduals.

20 (f) DUAL ELIGIBLE DEFINED.—In this section, the
21 term ''dual eligible individual'' means an individual who
22 is entitled to, or enrolled for, benefits under part A of title
23 XVIII of the Social Security Act, or enrolled for benefits
24 under part B of title XVIII of such Act, and is eligible

for medical assistance under a State plan under title XIX of such Act or under a waiver of such plan.

Subtitle I—Improving the Quality of Medicaid for Patients and Providers

SEC. 2701. ADULT HEALTH QUALITY MEASURES.

Title XI of the Social Security Act (42 U.S.C. 1301 et seq.), as amended by section 401 of the Children's Health Insurance Program Reauthorization Act of 2009 (Public Law 111-3), is amended by inserting after section 1139A the following new section:

"SEC. 1139B. ADULT HEALTH QUALITY MEASURES.

''(a) DEVELOPMENT OF CORE SET OF HEALTH CARE QUALITY MEASURES FOR ADULTS ELIGIBLE FOR BENEFITS UNDER MEDICAID.—The Secretary shall identify and publish a recommended core set of adult health quality measures for Medicaid eligible adults in the same manner as the Secretary identifies and publishes a core set of child health quality measures under section 1139A, including with respect to identifying and publishing existing adult health quality measures that are in use under public and privately sponsored health care coverage arrangements, or that are part of reporting systems that measure both the presence and duration of health insurance cov-

1 erage over time, that may be applicable to Medicaid eligi-
2 ble adults.

3 "(b) DEADLINES.—

4 "(1) RECOMMENDED MEASURES.—Not later
5 than January 1, 2011, the Secretary shall identify
6 and publish for comment a recommended core set of
7 adult health quality measures for Medicaid eligible
8 adults.

9 "(2) DISSEMINATION.—Not later than January
10 1, 2012, the Secretary shall publish an initial core
11 set of adult health quality measures that are appli-
12 cable to Medicaid eligible adults.

13 "(3) STANDARDIZED REPORTING.—Not later
14 than January 1, 2013, the Secretary, in consultation
15 with States, shall develop a standardized format for
16 reporting information based on the initial core set of
17 adult health quality measures and create procedures
18 to encourage States to use such measures to volun-
19 tarily report information regarding the quality of
20 health care for Medicaid eligible adults.

21 "(4) REPORTS TO CONGRESS.—Not later than
22 January 1, 2014, and every 3 years thereafter, the
23 Secretary shall include in the report to Congress re-
24 quired under section 1139A(a)(6) information simi-
25 lar to the information required under that section

with respect to the measures established under this section.

"(5) ESTABLISHMENT OF MEDICAID QUALITY MEASUREMENT PROGRAM.—

"(A) IN GENERAL.—Not later than 12 months after the release of the recommended core set of adult health quality measures under paragraph (1)), the Secretary shall establish a Medicaid Quality Measurement Program in the same manner as the Secretary establishes the pediatric quality measures program under section 1139A(b). The aggregate amount awarded by the Secretary for grants and contracts for the development, testing, and validation of emerging and innovative evidence-based measures under such program shall equal the aggregate amount awarded by the Secretary for grants under section 1139A(b)(4)(A)

"(B) REVISING, STRENGTHENING, AND IMPROVING INITIAL CORE MEASURES.—Beginning not later than 24 months after the establishment of the Medicaid Quality Measurement Program, and annually thereafter, the Secretary shall publish recommended changes to the initial core set of adult health quality meas-

1 ures that shall reflect the results of the testing,
2 validation, and consensus process for the devel-
3 opment of adult health quality measures.

4 "(c) CONSTRUCTION.—Nothing in this section shall
5 be construed as supporting the restriction of coverage,
6 under title XIX or XXI or otherwise, to only those services
7 that are evidence-based, or in anyway limiting available
8 services.

9 "(d) ANNUAL STATE REPORTS REGARDING STATE-
10 SPECIFIC QUALITY OF CARE MEASURES APPLIED UNDER
11 MEDICAID.—

12 "(1) ANNUAL STATE REPORTS.—Each State
13 with a State plan or waiver approved under title
14 XIX shall annually report (separately or as part of
15 the annual report required under section 1139A(c)),
16 to the Secretary on the—

17 "(A) State-specific adult health quality
18 measures applied by the State under the such
19 plan, including measures described in sub-
20 section (a)(5); and

21 "(B) State-specific information on the
22 quality of health care furnished to Medicaid eli-
23 gible adults under such plan, including informa-
24 tion collected through external quality reviews

of managed care organizations under section 1932 and benchmark plans under section 1937.

"(2) PUBLICATION.—Not later than September 30, 2014, and annually thereafter, the Secretary shall collect, analyze, and make publicly available the information reported by States under paragraph (1).

"(e) APPROPRIATION.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated for each of fiscal years 2010 through 2014, $60,000,000 for the purpose of carrying out this section. Funds appropriated under this subsection shall remain available until expended.".

SEC. 2702. PAYMENT ADJUSTMENT FOR HEALTH CARE-ACQUIRED CONDITIONS.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this subsection referred to as the "Secretary") shall identify current State practices that prohibit payment for health care-acquired conditions and shall incorporate the practices identified, or elements of such practices, which the Secretary determines appropriate for application to the Medicaid program in regulations. Such regulations shall be effective as of July 1, 2011, and shall prohibit payments to States under section 1903 of the Social Security Act for any amounts expended for providing medical assistance for health care-acquired

1 conditions specified in the regulations. The regulations
2 shall ensure that the prohibition on payment for health
3 care-acquired conditions shall not result in a loss of access
4 to care or services for Medicaid beneficiaries.

5 (b) HEALTH CARE-ACQUIRED CONDITION.—In this
6 section. the term ''health care-acquired condition'' means
7 a medical condition for which an individual was diagnosed
8 that could be identified by a secondary diagnostic code de-
9 scribed in section 1886(d)(4)(D)(iv) of the Social Security
10 Act (42 U.S.C. 1395ww(d)(4)(D)(iv)).

11 (c) MEDICARE PROVISIONS.—In carrying out this
12 section, the Secretary shall apply to State plans (or waiv-
13 ers) under title XIX of the Social Security Act the regula-
14 tions promulgated pursuant to section 1886(d)(4)(D) of
15 such Act (42 U.S.C. 1395ww(d)(4)(D)) relating to the
16 prohibition of payments based on the presence of a sec-
17 ondary diagnosis code specified by the Secretary in such
18 regulations, as appropriate for the Medicaid program. The
19 Secretary may exclude certain conditions identified under
20 title XVIII of the Social Security Act for non-payment
21 under title XIX of such Act when the Secretary finds the
22 inclusion of such conditions to be inapplicable to bene-
23 ficiaries under title XIX.

SEC. 2703. STATE OPTION TO PROVIDE HEALTH HOMES FOR ENROLLEES WITH CHRONIC CONDITIONS.

(a) STATE PLAN AMENDMENT.—Title XIX of the Social Security Act (42 U.S.C. 1396a et seq.), as amended by sections 2201 and 2305, is amended by adding at the end the following new section:

"SEC. 1945. STATE OPTION TO PROVIDE COORDINATED CARE THROUGH A HEALTH HOME FOR INDIVIDUALS WITH CHRONIC CONDITIONS.—

"(a) IN GENERAL.—Notwithstanding section 1902(a)(1) (relating to statewideness), section 1902(a)(10)(B) (relating to comparability), and any other provision of this title for which the Secretary determines it is necessary to waive in order to implement this section, beginning January 1, 2011, a State, at its option as a State plan amendment, may provide for medical assistance under this title to eligible individuals with chronic conditions who select a designated provider (as described under subsection (h)(5)), a team of health care professionals (as described under subsection (h)(6)) operating with such a provider, or a health team (as described under subsection (h)(7)) as the individual's health home for purposes of providing the individual with health home services.

"(b) HEALTH HOME QUALIFICATION STANDARDS.—The Secretary shall establish standards for qualification

as a designated provider for the purpose of being eligible to be a health home for purposes of this section.

"(c) PAYMENTS.—

"(1) IN GENERAL.—A State shall provide a designated provider, a team of health care professionals operating with such a provider, or a health team with payments for the provision of health home services to each eligible individual with chronic conditions that selects such provider, team of health care professionals, or health team as the individual's health home. Payments made to a designated provider, a team of health care professionals operating with such a provider, or a health team for such services shall be treated as medical assistance for purposes of section 1903(a), except that, during the first 8 fiscal year quarters that the State plan amendment is in effect, the Federal medical assistance percentage applicable to such payments shall be equal to 90 percent.

"(2) METHODOLOGY.—

"(A) IN GENERAL.—The State shall specify in the State plan amendment the methodology the State will use for determining payment for the provision of health home services. Such methodology for determining payment—

1 "(i) may be tiered to reflect, with re-
2 spect to each eligible individual with chron-
3 ic conditions provided such services by a
4 designated provider, a team of health care
5 professionals operating with such a pro-
6 vider, or a health team, as well as the se-
7 verity or number of each such individual's
8 chronic conditions or the specific capabili-
9 ties of the provider, team of health care
10 professionals, or health team; and
11 "(ii) shall be established consistent
12 with section 1902(a)(30)(A).
13 "(B) ALTERNATE MODELS OF PAYMENT.—
14 The methodology for determining payment for
15 provision of health home services under this
16 section shall not be limited to a per-member
17 per-month basis and may provide (as proposed
18 by the State and subject to approval by the
19 Secretary) for alternate models of payment.
20 "(3) PLANNING GRANTS.—
21 "(A) IN GENERAL.—Beginning January 1,
22 2011, the Secretary may award planning grants
23 to States for purposes of developing a State
24 plan amendment under this section. A planning

grant awarded to a State under this paragraph shall remain available until expended.

"(B) STATE CONTRIBUTION.—A State awarded a planning grant shall contribute an amount equal to the State percentage determined under section 1905(b) (without regard to section 5001 of Public Law 111–5) for each fiscal year for which the grant is awarded.

"(C) LIMITATION.—The total amount of payments made to States under this paragraph shall not exceed $25,000,000.

"(d) HOSPITAL REFERRALS.—A State shall include in the State plan amendment a requirement for hospitals that are participating providers under the State plan or a waiver of such plan to establish procedures for referring any eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated providers.

"(e) COORDINATION.—A State shall consult and coordinate, as appropriate, with the Substance Abuse and Mental Health Services Administration in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.

1 "(f) MONITORING.—A State shall include in the State
2 plan amendment—
3 "(1) a methodology for tracking avoidable hos-
4 pital readmissions and calculating savings that re-
5 sult from improved chronic care coordination and
6 management under this section; and
7 "(2) a proposal for use of health information
8 technology in providing health home services under
9 this section and improving service delivery and co-
10 ordination across the care continuum (including the
11 use of wireless patient technology to improve coordi-
12 nation and management of care and patient adher-
13 ence to recommendations made by their provider).
14 "(g) REPORT ON QUALITY MEASURES.—As a condi-
15 tion for receiving payment for health home services pro-
16 vided to an eligible individual with chronic conditions, a
17 designated provider shall report to the State, in accord-
18 ance with such requirements as the Secretary shall specify,
19 on all applicable measures for determining the quality of
20 such services. When appropriate and feasible, a designated
21 provider shall use health information technology in pro-
22 viding the State with such information.
23 "(h) DEFINITIONS.—In this section:
24 "(1) ELIGIBLE INDIVIDUAL WITH CHRONIC
25 CONDITIONS.—

"(A) IN GENERAL.—Subject to subparagraph (B), the term 'eligible individual with chronic conditions' means an individual who—

"(i) is eligible for medical assistance under the State plan or under a waiver of such plan; and

"(ii) has at least—

"(I) 2 chronic conditions;

"(II) 1 chronic condition and is at risk of having a second chronic condition; or

"(III) 1 serious and persistent mental health condition.

"(B) RULE OF CONSTRUCTION.—Nothing in this paragraph shall prevent the Secretary from establishing higher levels as to the number or severity of chronic or mental health conditions for purposes of determining eligibility for receipt of health home services under this section.

"(2) CHRONIC CONDITION.—The term 'chronic condition' has the meaning given that term by the Secretary and shall include, but is not limited to, the following:

"(A) A mental health condition.

1 "(B) Substance use disorder.
2 "(C) Asthma.
3 "(D) Diabetes.
4 "(E) Heart disease.
5 "(F) Being overweight, as evidenced by
6 having a Body Mass Index (BMI) over 25.
7 "(3) HEALTH HOME.—The term 'health home'
8 means a designated provider (including a provider
9 that operates in coordination with a team of health
10 care professionals) or a health team selected by an
11 eligible individual with chronic conditions to provide
12 health home services.
13 "(4) HEALTH HOME SERVICES.—
14 "(A) IN GENERAL.—The term 'health
15 home services' means comprehensive and timely
16 high-quality services described in subparagraph
17 (B) that are provided by a designated provider,
18 a team of health care professionals operating
19 with such a provider, or a health team.
20 "(B) SERVICES DESCRIBED.—The services
21 described in this subparagraph are—
22 "(i) comprehensive care management;
23 "(ii) care coordination and health pro-
24 motion;

1 "(iii) comprehensive transitional care,
2 including appropriate follow-up, from inpa-
3 tient to other settings;
4 "(iv) patient and family support (in-
5 cluding authorized representatives);
6 "(v) referral to community and social
7 support services, if relevant; and
8 "(vi) use of health information tech-
9 nology to link services, as feasible and ap-
10 propriate.
11 "(5) DESIGNATED PROVIDER.—The term 'des-
12 ignated provider' means a physician, clinical practice
13 or clinical group practice, rural clinic, community
14 health center, community mental health center,
15 home health agency, or any other entity or provider
16 (including pediatricians, gynecologists, and obstetri-
17 cians) that is determined by the State and approved
18 by the Secretary to be qualified to be a health home
19 for eligible individuals with chronic conditions on the
20 basis of documentation evidencing that the physi-
21 cian, practice, or clinic—
22 "(A) has the systems and infrastructure in
23 place to provide health home services; and

"(B) satisfies the qualification standards established by the Secretary under subsection (b).

"(6) TEAM OF HEALTH CARE PROFESSIONALS.—The term 'team of health care professionals' means a team of health professionals (as described in the State plan amendment) that may—

"(A) include physicians and other professionals, such as a nurse care coordinator, nutritionist, social worker, behavioral health professional, or any professionals deemed appropriate by the State; and

"(B) be free standing, virtual, or based at a hospital, community health center, community mental health center, rural clinic, clinical practice or clinical group practice, academic health center, or any entity deemed appropriate by the State and approved by the Secretary.

"(7) HEALTH TEAM.—The term 'health team' has the meaning given such term for purposes of section 3502 of the Patient Protection and Affordable Care Act.".

(b) EVALUATION.—

(1) INDEPENDENT EVALUATION.—

1 (A) IN GENERAL.—The Secretary shall
2 enter into a contract with an independent entity
3 or organization to conduct an evaluation and
4 assessment of the States that have elected the
5 option to provide coordinated care through a
6 health home for Medicaid beneficiaries with
7 chronic conditions under section 1945 of the
8 Social Security Act (as added by subsection (a))
9 for the purpose of determining the effect of
10 such option on reducing hospital admissions,
11 emergency room visits, and admissions to
12 skilled nursing facilities.
13 (B) EVALUATION REPORT.—Not later than
14 January 1, 2017, the Secretary shall report to
15 Congress on the evaluation and assessment con-
16 ducted under subparagraph (A).
17 (2) SURVEY AND INTERIM REPORT.—
18 (A) IN GENERAL.—Not later than January
19 1, 2014, the Secretary of Health and Human
20 Services shall survey States that have elected
21 the option under section 1945 of the Social Se-
22 curity Act (as added by subsection (a)) and re-
23 port to Congress on the nature, extent, and use
24 of such option, particularly as it pertains to—
25 (i) hospital admission rates;

(ii) chronic disease management;

(iii) coordination of care for individuals with chronic conditions;

(iv) assessment of program implementation;

(v) processes and lessons learned (as described in subparagraph (B));

(vi) assessment of quality improvements and clinical outcomes under such option; and

(vii) estimates of cost savings.

(B) IMPLEMENTATION REPORTING.—A State that has elected the option under section 1945 of the Social Security Act (as added by subsection (a)) shall report to the Secretary, as necessary, on processes that have been developed and lessons learned regarding provision of coordinated care through a health home for Medicaid beneficiaries with chronic conditions under such option.

SEC. 2704. DEMONSTRATION PROJECT TO EVALUATE INTEGRATED CARE AROUND A HOSPITALIZATION.

(a) AUTHORITY TO CONDUCT PROJECT.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the

1 "Secretary") shall establish a demonstration project
2 under title XIX of the Social Security Act to evalu-
3 ate the use of bundled payments for the provision of
4 integrated care for a Medicaid beneficiary—
5 (A) with respect to an episode of care that
6 includes a hospitalization; and
7 (B) for concurrent physicians services pro-
8 vided during a hospitalization.
9 (2) DURATION.—The demonstration project
10 shall begin on January 1, 2012, and shall end on
11 December 31, 2016.
12 (b) REQUIREMENTS.—The demonstration project
13 shall be conducted in accordance with the following:
14 (1) The demonstration project shall be con-
15 ducted in up to 8 States, determined by the Sec-
16 retary based on consideration of the potential to
17 lower costs under the Medicaid program while im-
18 proving care for Medicaid beneficiaries. A State se-
19 lected to participate in the demonstration project
20 may target the demonstration project to particular
21 categories of beneficiaries, beneficiaries with par-
22 ticular diagnoses, or particular geographic regions of
23 the State, but the Secretary shall insure that, as a
24 whole, the demonstration project is, to the greatest
25 extent possible, representative of the demographic

1 and geographic composition of Medicaid beneficiaries
2 nationally.
3 (2) The demonstration project shall focus on
4 conditions where there is evidence of an opportunity
5 for providers of services and suppliers to improve the
6 quality of care furnished to Medicaid beneficiaries
7 while reducing total expenditures under the State
8 Medicaid programs selected to participate, as deter-
9 mined by the Secretary.
10 (3) A State selected to participate in the dem-
11 onstration project shall specify the 1 or more epi-
12 sodes of care the State proposes to address in the
13 project, the services to be included in the bundled
14 payments, and the rationale for the selection of such
15 episodes of care and services. The Secretary may
16 modify the episodes of care as well as the services
17 to be included in the bundled payments prior to or
18 after approving the project. The Secretary may also
19 vary such factors among the different States partici-
20 pating in the demonstration project.
21 (4) The Secretary shall ensure that payments
22 made under the demonstration project are adjusted
23 for severity of illness and other characteristics of
24 Medicaid beneficiaries within a category or having a
25 diagnosis targeted as part of the demonstration

1 project. States shall ensure that Medicaid bene-
2 ficiaries are not liable for any additional cost sharing
3 than if their care had not been subject to payment
4 under the demonstration project.

5 (5) Hospitals participating in the demonstration
6 project shall have or establish robust discharge plan-
7 ning programs to ensure that Medicaid beneficiaries
8 requiring post-acute care are appropriately placed in,
9 or have ready access to, post-acute care settings.

10 (6) The Secretary and each State selected to
11 participate in the demonstration project shall ensure
12 that the demonstration project does not result in the
13 Medicaid beneficiaries whose care is subject to pay-
14 ment under the demonstration project being pro-
15 vided with less items and services for which medical
16 assistance is provided under the State Medicaid pro-
17 gram than the items and services for which medical
18 assistance would have been provided to such bene-
19 ficiaries under the State Medicaid program in the
20 absence of the demonstration project.

21 (c) WAIVER OF PROVISIONS.—Notwithstanding sec-
22 tion 1115(a) of the Social Security Act (42 U.S.C.
23 1315(a)), the Secretary may waive such provisions of titles
24 XIX, XVIII, and XI of that Act as may be necessary to
25 accomplish the goals of the demonstration, ensure bene-

1 ficiary access to acute and post-acute care, and maintain
2 quality of care.

3 (d) EVALUATION AND REPORT.—

4 (1) DATA.—Each State selected to participate
5 in the demonstration project under this section shall
6 provide to the Secretary, in such form and manner
7 as the Secretary shall specify, relevant data nec-
8 essary to monitor outcomes, costs, and quality, and
9 evaluate the rationales for selection of the episodes
10 of care and services specified by States under sub-
11 section (b)(3).

12 (2) REPORT.—Not later than 1 year after the
13 conclusion of the demonstration project, the Sec-
14 retary shall submit a report to Congress on the re-
15 sults of the demonstration project.

16 **SEC. 2705. MEDICAID GLOBAL PAYMENT SYSTEM DEM-**
17 **ONSTRATION PROJECT.**

18 (a) IN GENERAL.—The Secretary of Health and
19 Human Services (referred to in this section as the ''Sec-
20 retary'') shall, in coordination with the Center for Medi-
21 care and Medicaid Innovation (as established under sec-
22 tion 1115A of the Social Security Act, as added by section
23 3021 of this Act), establish the Medicaid Global Payment
24 System Demonstration Project under which a partici-
25 pating State shall adjust the payments made to an eligible

1 safety net hospital system or network from a fee-for-serv-
2 ice payment structure to a global capitated payment
3 model.

4 (b) DURATION AND SCOPE.—The demonstration
5 project conducted under this section shall operate during
6 a period of fiscal years 2010 through 2012. The Secretary
7 shall select not more than 5 States to participate in the
8 demonstration project.

9 (c) ELIGIBLE SAFETY NET HOSPITAL SYSTEM OR
10 NETWORK.—For purposes of this section, the term ''eligi-
11 ble safety net hospital system or network'' means a large,
12 safety net hospital system or network (as defined by the
13 Secretary) that operates within a State selected by the
14 Secretary under subsection (b).

15 (d) EVALUATION.—

16 (1) TESTING.—The Innovation Center shall test
17 and evaluate the demonstration project conducted
18 under this section to examine any changes in health
19 care quality outcomes and spending by the eligible
20 safety net hospital systems or networks.

21 (2) BUDGET NEUTRALITY.—During the testing
22 period under paragraph (1), any budget neutrality
23 requirements under section 1115A(b)(3) of the So-
24 cial Security Act (as so added) shall not be applica-
25 ble.

(3) MODIFICATION.—During the testing period under paragraph (1), the Secretary may, in the Secretary's discretion, modify or terminate the demonstration project conducted under this section.

(e) REPORT.—Not later than 12 months after the date of completion of the demonstration project under this section, the Secretary shall submit to Congress a report containing the results of the evaluation and testing conducted under subsection (d), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out this section.

SEC. 2706. PEDIATRIC ACCOUNTABLE CARE ORGANIZATION DEMONSTRATION PROJECT.

(a) AUTHORITY TO CONDUCT DEMONSTRATION.—

(1) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall establish the Pediatric Accountable Care Organization Demonstration Project to authorize a participating State to allow pediatric medical providers that meet specified requirements to be recognized as an accountable care organization for purposes of receiving incentive payments (as de-

1 scribed under subsection (d)), in the same manner
2 as an accountable care organization is recognized
3 and provided with incentive payments under section
4 1899 of the Social Security Act (as added by section
5 3022).

6 (2) DURATION.—The demonstration project
7 shall begin on January 1, 2012, and shall end on
8 December 31, 2016.

9 (b) APPLICATION.—A State that desires to partici-
10 pate in the demonstration project under this section shall
11 submit to the Secretary an application at such time, in
12 such manner, and containing such information as the Sec-
13 retary may require.

14 (c) REQUIREMENTS.—

15 (1) PERFORMANCE GUIDELINES.—The Sec-
16 retary, in consultation with the States and pediatric
17 providers, shall establish guidelines to ensure that
18 the quality of care delivered to individuals by a pro-
19 vider recognized as an accountable care organization
20 under this section is not less than the quality of care
21 that would have otherwise been provided to such in-
22 dividuals.

23 (2) SAVINGS REQUIREMENT.—A participating
24 State, in consultation with the Secretary, shall es-
25 tablish an annual minimal level of savings in expend-

itures for items and services covered under the Medicaid program under title XIX of the Social Security Act and the CHIP program under title XXI of such Act that must be reached by an accountable care organization in order for such organization to receive an incentive payment under subsection (d).

(3) MINIMUM PARTICIPATION PERIOD.—A provider desiring to be recognized as an accountable care organization under the demonstration project shall enter into an agreement with the State to participate in the project for not less than a 3-year period.

(d) INCENTIVE PAYMENT.—An accountable care organization that meets the performance guidelines established by the Secretary under subsection (c)(1) and achieves savings greater than the annual minimal savings level established by the State under subsection (c)(2) shall receive an incentive payment for such year equal to a portion (as determined appropriate by the Secretary) of the amount of such excess savings. The Secretary may establish an annual cap on incentive payments for an accountable care organization.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out this section.

SEC. 2707. MEDICAID EMERGENCY PSYCHIATRIC DEMONSTRATION PROJECT.

(a) AUTHORITY TO CONDUCT DEMONSTRATION PROJECT.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish a demonstration project under which an eligible State (as described in subsection (c)) shall provide payment under the State Medicaid plan under title XIX of the Social Security Act to an institution for mental diseases that is not publicly owned or operated and that is subject to the requirements of section 1867 of the Social Security Act (42 U.S.C. 1395dd) for the provision of medical assistance available under such plan to individuals who—

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

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

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

(b) STABILIZATION REVIEW.—A State shall specify in its application described in subsection (c)(1) establish a mechanism for how it will ensure that institutions participating in the demonstration will determine whether or not such individuals have been stabilized (as defined in subsection (h)(5)) . This mechanism shall commence before the third day of the inpatient stay. States partici-

1 pating in the demonstration project may manage the pro-
2 vision of services for the stabilization of medical emer-
3 gency conditions through utilization review, authorization,
4 or management practices, or the application of medical ne-
5 cessity and appropriateness criteria applicable to behav-
6 ioral health.

7 (c) ELIGIBLE STATE DEFINED.—

8 (1) IN GENERAL.—An eligible State is a State
9 that has made an application and has been selected
10 pursuant to paragraphs (2) and (3).

11 (2) APPLICATION.—A State seeking to partici-
12 pate in the demonstration project under this section
13 shall submit to the Secretary, at such time and in
14 such format as the Secretary requires, an applica-
15 tion that includes such information, provisions, and
16 assurances, as the Secretary may require.

17 (3) SELECTION.—A State shall be determined
18 eligible for the demonstration by the Secretary on a
19 competitive basis among States with applications
20 meeting the requirements of paragraph (1). In se-
21 lecting State applications for the demonstration
22 project, the Secretary shall seek to achieve an appro-
23 priate national balance in the geographic distribu-
24 tion of such projects.

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

(e) LIMITATIONS ON FEDERAL FUNDING.—

(1) APPROPRIATION.—

(A) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to carry out this section, $75,000,000 for fiscal year 2011.

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

(2) 5-YEAR AVAILABILITY.—Funds appropriated under paragraph (1) shall remain available for obligation through December 31, 2015.

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

(A) the aggregate amount of payments made by the Secretary to eligible States under this section exceed $75,000,000; or

(B) payments be provided by the Secretary under this section after December 31, 2015.

1 (4) FUNDS ALLOCATED TO STATES.—Funds
2 shall be allocated to eligible States on the basis of
3 criteria, including a State's application and the
4 availability of funds, as determined by the Secretary.
5 (5) PAYMENTS TO STATES.—The Secretary
6 shall pay to each eligible State, from its allocation
7 under paragraph (4), an amount each quarter equal
8 to the Federal medical assistance percentage of ex-
9 penditures in the quarter for medical assistance de-
10 scribed in subsection (a). As a condition of receiving
11 payment, a State shall collect and report informa-
12 tion, as determined necessary by the Secretary, for
13 the purposes of providing Federal oversight and con-
14 ducting an evaluation under subsection (f)(1).
15 (f) EVALUATION AND REPORT TO CONGRESS.—
16 (1) EVALUATION.—The Secretary shall conduct
17 an evaluation of the demonstration project in order
18 to determine the impact on the functioning of the
19 health and mental health service system and on indi-
20 viduals enrolled in the Medicaid program and shall
21 include the following:
22 (A) An assessment of access to inpatient
23 mental health services under the Medicaid pro-
24 gram; average lengths of inpatient stays; and
25 emergency room visits.

(B) An assessment of discharge planning by participating hospitals.

(C) An assessment of the impact of the demonstration project on the costs of the full range of mental health services (including inpatient, emergency and ambulatory care).

(D) An analysis of the percentage of consumers with Medicaid coverage who are admitted to inpatient facilities as a result of the demonstration project as compared to those admitted to these same facilities through other means.

(E) A recommendation regarding whether the demonstration project should be continued after December 31, 2013, and expanded on a national basis.

(2) REPORT.—Not later than December 31, 2013, the Secretary shall submit to Congress and make available to the public a report on the findings of the evaluation under paragraph (1).

(g) WAIVER AUTHORITY.—

(1) IN GENERAL.—The Secretary shall waive the limitation of subdivision (B) following paragraph (28) of section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) (relating to limitations on pay-

ments for care or services for individuals under 65 years of age who are patients in an institution for mental diseases) for purposes of carrying out the demonstration project under this section.

(2) LIMITED OTHER WAIVER AUTHORITY.—The Secretary may waive other requirements of titles XI and XIX of the Social Security Act (including the requirements of sections 1902(a)(1) (relating to statewideness) and 1902(1)(10)(B) (relating to comparability)) only to extent necessary to carry out the demonstration project under this section.

(h) DEFINITIONS.—In this section:

(1) EMERGENCY MEDICAL CONDITION.—The term ''emergency medical condition'' means, with respect to an individual, an individual who expresses suicidal or homicidal thoughts or gestures, if determined dangerous to self or others.

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

(3) INSTITUTION FOR MENTAL DISEASES.—The term ''institution for mental diseases'' has the mean-

ing given to that term in section 1905(i) of the Social Security Act (42 U.S.C. 1396d(i)).

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

(5) STABILIZED.—The term ''stabilized'' means, with respect to an individual, that the emergency medical condition no longer exists with respect to the individual and the individual is no longer dangerous to self or others.

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

Subtitle J—Improvements to the Medicaid and CHIP Payment and Access Commission (MACPAC)

SEC. 2801. MACPAC ASSESSMENT OF POLICIES AFFECTING ALL MEDICAID BENEFICIARIES.

(a) IN GENERAL.—Section 1900 of the Social Security Act (42 U.S.C. 1396) is amended—

(1) in subsection (b)—

(A) in paragraph (1)—

(i) in the paragraph heading, by inserting ''FOR ALL STATES'' before ''AND ANNUAL''; and

(ii) in subparagraph (A), by striking ''children's'';

(iii) in subparagraph (B), by inserting '', the Secretary, and States'' after ''Congress'';

(iv) in subparagraph (C), by striking ''March 1'' and inserting ''March 15''; and

(v) in subparagraph (D), by striking ''June 1'' and inserting ''June 15'';

(B) in paragraph (2)—

(i) in subparagraph (A)—

(I) in clause (i)—

(aa) by inserting ''the efficient provision of'' after ''expenditures for''; and

(bb) by striking ''hospital, skilled nursing facility, physician, Federally-qualified health center, rural health center, and other fees'' and inserting ''payments to medical, dental, and health professionals, hospitals, residential

1 and long-term care providers,
2 providers of home and commu-
3 nity based services, Federally-
4 qualified health centers and rural
5 health clinics, managed care enti-
6 ties, and providers of other cov-
7 ered items and services''; and
8 (II) in clause (iii), by inserting
9 ''(including how such factors and
10 methodologies enable such bene-
11 ficiaries to obtain the services for
12 which they are eligible, affect provider
13 supply, and affect providers that serve
14 a disproportionate share of low-income
15 and other vulnerable populations)''
16 after ''beneficiaries'';
17 (ii) by redesignating subparagraphs
18 (B) and (C) as subparagraphs (F) and
19 (H), respectively;
20 (iii) by inserting after subparagraph
21 (A), the following:
22 ''(B) ELIGIBILITY POLICIES.—Medicaid
23 and CHIP eligibility policies, including a deter-
24 mination of the degree to which Federal and

1 State policies provide health care coverage to
2 needy populations.
3 "(C) ENROLLMENT AND RETENTION PROC-
4 ESSES.—Medicaid and CHIP enrollment and
5 retention processes, including a determination
6 of the degree to which Federal and State poli-
7 cies encourage the enrollment of individuals
8 who are eligible for such programs and screen
9 out individuals who are ineligible, while mini-
10 mizing the share of program expenses devoted
11 to such processes.
12 "(D) COVERAGE POLICIES.—Medicaid and
13 CHIP benefit and coverage policies, including a
14 determination of the degree to which Federal
15 and State policies provide access to the services
16 enrollees require to improve and maintain their
17 health and functional status.
18 "(E) QUALITY OF CARE.—Medicaid and
19 CHIP policies as they relate to the quality of
20 care provided under those programs, including
21 a determination of the degree to which Federal
22 and State policies achieve their stated goals and
23 interact with similar goals established by other
24 purchasers of health care services.";

(iv) by inserting after subparagraph (F) (as redesignated by clause (ii) of this subparagraph), the following:

"(G) INTERACTIONS WITH MEDICARE AND MEDICAID.—Consistent with paragraph (11), the interaction of policies under Medicaid and the Medicare program under title XVIII, including with respect to how such interactions affect access to services, payments, and dual eligible individuals." and

(v) in subparagraph (H) (as so redesignated), by inserting "and preventive, acute, and long-term services and supports" after "barriers";

(C) by redesignating paragraphs (3) through (9) as paragraphs (4) through (10), respectively;

(D) by inserting after paragraph (2), the following new paragraph:

"(3) RECOMMENDATIONS AND REPORTS OF STATE-SPECIFIC DATA.—MACPAC shall—

"(A) review national and State-specific Medicaid and CHIP data; and

"(B) submit reports and recommendations to Congress, the Secretary, and States based on such reviews.";

(E) in paragraph (4), as redesignated by subparagraph (C), by striking "or any other problems" and all that follows through the period and inserting ", as well as other factors that adversely affect, or have the potential to adversely affect, access to care by, or the health care status of, Medicaid and CHIP beneficiaries. MACPAC shall include in the annual report required under paragraph (1)(D) a description of all such areas or problems identified with respect to the period addressed in the report.";

(F) in paragraph (5), as so redesignated,—

(i) in the paragraph heading, by inserting "AND REGULATIONS" after "REPORTS"; and

(ii) by striking "If" and inserting the following:

"(A) CERTAIN SECRETARIAL REPORTS.—If"; and

(iii) in the second sentence, by inserting ''and the Secretary'' after ''appropriate committees of Congress''; and

(iv) by adding at the end the following:

''(B) REGULATIONS.—MACPAC shall review Medicaid and CHIP regulations and may comment through submission of a report to the appropriate committees of Congress and the Secretary, on any such regulations that affect access, quality, or efficiency of health care.'';

(G) in paragraph (10), as so redesignated, by inserting '', and shall submit with any recommendations, a report on the Federal and State-specific budget consequences of the recommendations'' before the period; and

(H) by adding at the end the following:

''(11) CONSULTATION AND COORDINATION WITH MEDPAC.—

''(A) IN GENERAL.—MACPAC shall consult with the Medicare Payment Advisory Commission (in this paragraph referred to as 'MedPAC') established under section 1805 in carrying out its duties under this section, as appropriate and particularly with respect to the

1 issues specified in paragraph (2) as they relate
2 to those Medicaid beneficiaries who are dually
3 eligible for Medicaid and the Medicare program
4 under title XVIII, adult Medicaid beneficiaries
5 (who are not dually eligible for Medicare), and
6 beneficiaries under Medicare. Responsibility for
7 analysis of and recommendations to change
8 Medicare policy regarding Medicare bene-
9 ficiaries, including Medicare beneficiaries who
10 are dually eligible for Medicare and Medicaid,
11 shall rest with MedPAC.

12 ''(B) INFORMATION SHARING.—MACPAC
13 and MedPAC shall have access to deliberations
14 and records of the other such entity, respec-
15 tively, upon the request of the other such enti-
16 ty.

17 ''(12) CONSULTATION WITH STATES.—
18 MACPAC shall regularly consult with States in car-
19 rying out its duties under this section, including
20 with respect to developing processes for carrying out
21 such duties, and shall ensure that input from States
22 is taken into account and represented in MACPAC's
23 recommendations and reports.

24 ''(13) COORDINATE AND CONSULT WITH THE
25 FEDERAL COORDINATED HEALTH CARE OFFICE.—

1 MACPAC shall coordinate and consult with the Fed-
2 eral Coordinated Health Care Office established
3 under section 2081 of the Patient Protection and
4 Affordable Care Act before making any rec-
5 ommendations regarding dual eligible individuals.

6 "(14) PROGRAMMATIC OVERSIGHT VESTED IN
7 THE SECRETARY.—MACPAC's authority to make
8 recommendations in accordance with this section
9 shall not affect, or be considered to duplicate, the
10 Secretary's authority to carry out Federal respon-
11 sibilities with respect to Medicaid and CHIP.";

12 (2) in subsection (c)(2)—

13 (A) by striking subparagraphs (A) and (B)
14 and inserting the following:

15 "(A) IN GENERAL.—The membership of
16 MACPAC shall include individuals who have
17 had direct experience as enrollees or parents or
18 caregivers of enrollees in Medicaid or CHIP and
19 individuals with national recognition for their
20 expertise in Federal safety net health programs,
21 health finance and economics, actuarial science,
22 health plans and integrated delivery systems,
23 reimbursement for health care, health informa-
24 tion technology, and other providers of health
25 services, public health, and other related fields,

who provide a mix of different professions, broad geographic representation, and a balance between urban and rural representation.

"(B) INCLUSION.—The membership of MACPAC shall include (but not be limited to) physicians, dentists, and other health professionals, employers, third-party payers, and individuals with expertise in the delivery of health services. Such membership shall also include representatives of children, pregnant women, the elderly, individuals with disabilities, caregivers, and dual eligible individuals, current or former representatives of State agencies responsible for administering Medicaid, and current or former representatives of State agencies responsible for administering CHIP.".

(3) in subsection (d)(2), by inserting "and State" after "Federal";

(4) in subsection (e)(1), in the first sentence, by inserting "and, as a condition for receiving payments under sections 1903(a) and 2105(a), from any State agency responsible for administering Medicaid or CHIP," after "United States"; and

(5) in subsection (f)—

(A) in the subsection heading, by striking ''AUTHORIZATION OF APPROPRIATIONS'' and inserting ''FUNDING'';

(B) in paragraph (1), by inserting ''(other than for fiscal year 2010)'' before ''in the same manner''; and

(C) by adding at the end the following:

''(3) FUNDING FOR FISCAL YEAR 2010.—

''(A) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to MACPAC to carry out the provisions of this section for fiscal year 2010, $9,000,000.

''(B) TRANSFER OF FUNDS.—Notwithstanding section 2104(a)(13), from the amounts appropriated in such section for fiscal year 2010, $2,000,000 is hereby transferred and made available in such fiscal year to MACPAC to carry out the provisions of this section.

''(4) AVAILABILITY.—Amounts made available under paragraphs (2) and (3) to MACPAC to carry out the provisions of this section shall remain available until expended.''.

(b) CONFORMING MEDPAC AMENDMENTS.—Section 1805(b) of the Social Security Act (42 U.S.C. 1395b–6(b)), is amended—

(1) in paragraph (1)(C), by striking ''March 1 of each year (beginning with 1998)'' and inserting ''March 15'';

(2) in paragraph (1)(D), by inserting '', and (beginning with 2012) containing an examination of the topics described in paragraph (9), to the extent feasible'' before the period; and

(3) by adding at the end the following:

''(9) REVIEW AND ANNUAL REPORT ON MEDICAID AND COMMERCIAL TRENDS.—The Commission shall review and report on aggregate trends in spending, utilization, and financial performance under the Medicaid program under title XIX and the private market for health care services with respect to providers for which, on an aggregate national basis, a significant portion of revenue or services is associated with the Medicaid program. Where appropriate, the Commission shall conduct such review in consultation with the Medicaid and CHIP Payment and Access Commission established under section 1900 (in this section referred to as 'MACPAC').

"(10) COORDINATE AND CONSULT WITH THE FEDERAL COORDINATED HEALTH CARE OFFICE.—The Commission shall coordinate and consult with the Federal Coordinated Health Care Office established under section 2081 of the Patient Protection and Affordable Care Act before making any recommendations regarding dual eligible individuals.

"(11) INTERACTION OF MEDICAID AND MEDICARE.—The Commission shall consult with MACPAC in carrying out its duties under this section, as appropriate. Responsibility for analysis of and recommendations to change Medicare policy regarding Medicare beneficiaries, including Medicare beneficiaries who are dually eligible for Medicare and Medicaid, shall rest with the Commission. Responsibility for analysis of and recommendations to change Medicaid policy regarding Medicaid beneficiaries, including Medicaid beneficiaries who are dually eligible for Medicare and Medicaid, shall rest with MACPAC.".

Subtitle K—Protections for American Indians and Alaska Natives

SEC. 2901. SPECIAL RULES RELATING TO INDIANS.

(a) NO COST-SHARING FOR INDIANS WITH INCOME AT OR BELOW 300 PERCENT OF POVERTY ENROLLED IN

1 COVERAGE THROUGH A STATE EXCHANGE.—For provi-
2 sions prohibiting cost sharing for Indians enrolled in any
3 qualified health plan in the individual market through an
4 Exchange, see section 1402(d) of the Patient Protection
5 and Affordable Care Act.

6 (b) PAYER OF LAST RESORT.—Health programs op-
7 erated by the Indian Health Service, Indian tribes, tribal
8 organizations, and Urban Indian organizations (as those
9 terms are defined in section 4 of the Indian Health Care
10 Improvement Act (25 U.S.C. 1603)) shall be the payer
11 of last resort for services provided by such Service, tribes,
12 or organizations to individuals eligible for services through
13 such programs, notwithstanding any Federal, State, or
14 local law to the contrary.

15 (c) FACILITATING ENROLLMENT OF INDIANS UNDER
16 THE EXPRESS LANE OPTION.—Section
17 1902(e)(13)(F)(ii) of the Social Security Act (42 U.S.C.
18 1396a(e)(13)(F)(ii)) is amended—

19 (1) in the clause heading, by inserting ''AND IN-
20 DIAN TRIBES AND TRIBAL ORGANIZATIONS'' after
21 ''AGENCIES''; and

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

23 ''(IV) The Indian Health Service,
24 an Indian Tribe, Tribal Organization,

or Urban Indian Organization (as defined in section 1139(c)).''.

(d) TECHNICAL CORRECTIONS.—Section 1139(c) of the Social Security Act (42 U.S.C. 1320b–9(c)) is amended by striking ''In this section'' and inserting ''For purposes of this section, title XIX, and title XXI''.

SEC. 2902. ELIMINATION OF SUNSET FOR REIMBURSEMENT FOR ALL MEDICARE PART B SERVICES FURNISHED BY CERTAIN INDIAN HOSPITALS AND CLINICS.

(a) REIMBURSEMENT FOR ALL MEDICARE PART B SERVICES FURNISHED BY CERTAIN INDIAN HOSPITALS AND CLINICS.—Section 1880(e)(1)(A) of the Social Security Act (42 U.S.C. 1395qq(e)(1)(A)) is amended by striking ''during the 5-year period beginning on'' and inserting ''on or after''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to items or services furnished on or after January 1, 2010.

Subtitle L—Maternal and Child Health Services

SEC. 2951. MATERNAL, INFANT, AND EARLY CHILDHOOD HOME VISITING PROGRAMS.

Title V of the Social Security Act (42 U.S.C. 701 et seq.) is amended by adding at the end the following new section:

"SEC. 511. MATERNAL, INFANT, AND EARLY CHILDHOOD HOME VISITING PROGRAMS.

''(a) PURPOSES.—The purposes of this section are—

''(1) to strengthen and improve the programs and activities carried out under this title;

''(2) to improve coordination of services for at risk communities; and

''(3) to identify and provide comprehensive services to improve outcomes for families who reside in at risk communities.

''(b) REQUIREMENT FOR ALL STATES TO ASSESS STATEWIDE NEEDS AND IDENTIFY AT RISK COMMUNITIES.—

''(1) IN GENERAL.—Not later than 6 months after the date of enactment of this section, each State shall, as a condition of receiving payments from an allotment for the State under section 502 for fiscal year 2011, conduct a statewide needs as-

1 sessment (which shall be separate from the statewide
2 needs assessment required under section 505(a))
3 that identifies—
4 ''(A) communities with concentrations of—
5 ''(i) premature birth, low-birth weight
6 infants, and infant mortality, including in-
7 fant death due to neglect, or other indica-
8 tors of at-risk prenatal, maternal, newborn,
9 or child health;
10 ''(ii) poverty;
11 ''(iii) crime;
12 ''(iv) domestic violence;
13 ''(v) high rates of high-school drop-
14 outs;
15 ''(vi) substance abuse;
16 ''(vii) unemployment; or
17 ''(viii) child maltreatment;
18 ''(B) the quality and capacity of existing
19 programs or initiatives for early childhood home
20 visitation in the State including—
21 ''(i) the number and types of individ-
22 uals and families who are receiving services
23 under such programs or initiatives;
24 ''(ii) the gaps in early childhood home
25 visitation in the State; and

"(iii) the extent to which such programs or initiatives are meeting the needs of eligible families described in subsection (k)(2); and

"(C) the State's capacity for providing substance abuse treatment and counseling services to individuals and families in need of such treatment or services.

"(2) COORDINATION WITH OTHER ASSESSMENTS.—In conducting the statewide needs assessment required under paragraph (1), the State shall coordinate with, and take into account, other appropriate needs assessments conducted by the State, as determined by the Secretary, including the needs assessment required under section 505(a) (both the most recently completed assessment and any such assessment in progress), the communitywide strategic planning and needs assessments conducted in accordance with section 640(g)(1)(C) of the Head Start Act, and the inventory of current unmet needs and current community-based and prevention-focused programs and activities to prevent child abuse and neglect, and other family resource services operating in the State required under section 205(3) of the Child Abuse Prevention and Treatment Act.

"(3) SUBMISSION TO THE SECRETARY.—Each State shall submit to the Secretary, in such form and manner as the Secretary shall require—

"(A) the results of the statewide needs assessment required under paragraph (1); and

"(B) a description of how the State intends to address needs identified by the assessment, particularly with respect to communities identified under paragraph (1)(A), which may include applying for a grant to conduct an early childhood home visitation program in accordance with the requirements of this section.

"(c) GRANTS FOR EARLY CHILDHOOD HOME VISITATION PROGRAMS.—

"(1) AUTHORITY TO MAKE GRANTS.—In addition to any other payments made under this title to a State, the Secretary shall make grants to eligible entities to enable the entities to deliver services under early childhood home visitation programs that satisfy the requirements of subsection (d) to eligible families in order to promote improvements in maternal and prenatal health, infant health, child health and development, parenting related to child development outcomes, school readiness, and the socio-

economic status of such families, and reductions in child abuse, neglect, and injuries.

"(2) AUTHORITY TO USE INITIAL GRANT FUNDS FOR PLANNING OR IMPLEMENTATION.—An eligible entity that receives a grant under paragraph (1) may use a portion of the funds made available to the entity during the first 6 months of the period for which the grant is made for planning or implementation activities to assist with the establishment of early childhood home visitation programs that satisfy the requirements of subsection (d).

"(3) GRANT DURATION.—The Secretary shall determine the period of years for which a grant is made to an eligible entity under paragraph (1).

"(4) TECHNICAL ASSISTANCE.—The Secretary shall provide an eligible entity that receives a grant under paragraph (1) with technical assistance in administering programs or activities conducted in whole or in part with grant funds.

"(d) REQUIREMENTS.—The requirements of this subsection for an early childhood home visitation program conducted with a grant made under this section are as follows:

"(1) QUANTIFIABLE, MEASURABLE IMPROVEMENT IN BENCHMARK AREAS.—

"(A) IN GENERAL.—The eligible entity establishes, subject to the approval of the Secretary, quantifiable, measurable 3- and 5-year benchmarks for demonstrating that the program results in improvements for the eligible families participating in the program in each of the following areas:

"(i) Improved maternal and newborn health.

"(ii) Prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits.

"(iii) Improvement in school readiness and achievement.

"(iv) Reduction in crime or domestic violence.

"(v) Improvements in family economic self-sufficiency.

"(vi) Improvements in the coordination and referrals for other community resources and supports.

"(B) DEMONSTRATION OF IMPROVEMENTS AFTER 3 YEARS.—

"(i) REPORT TO THE SECRETARY.—Not later than 30 days after the end of the

3rd year in which the eligible entity conducts the program, the entity submits to the Secretary a report demonstrating improvement in at least 4 of the areas specified in subparagraph (A).

"(ii) CORRECTIVE ACTION PLAN.—If the report submitted by the eligible entity under clause (i) fails to demonstrate improvement in at least 4 of the areas specified in subparagraph (A), the entity shall develop and implement a plan to improve outcomes in each of the areas specified in subparagraph (A), subject to approval by the Secretary. The plan shall include provisions for the Secretary to monitor implementation of the plan and conduct continued oversight of the program, including through submission by the entity of regular reports to the Secretary.

"(iii) TECHNICAL ASSISTANCE.—

"(I) IN GENERAL.—The Secretary shall provide an eligible entity required to develop and implement an improvement plan under clause (ii) with technical assistance to develop

and implement the plan. The Secretary may provide the technical assistance directly or through grants, contracts, or cooperative agreements.

"(II) ADVISORY PANEL.—The Secretary shall establish an advisory panel for purposes of obtaining recommendations regarding the technical assistance provided to entities in accordance with subclause (I).

"(iv) NO IMPROVEMENT OR FAILURE TO SUBMIT REPORT.—If the Secretary determines after a period of time specified by the Secretary that an eligible entity implementing an improvement plan under clause (ii) has failed to demonstrate any improvement in the areas specified in subparagraph (A), or if the Secretary determines that an eligible entity has failed to submit the report required under clause (i), the Secretary shall terminate the entity's grant and may include any unexpended grant funds in grants made to nonprofit organizations under subsection (h)(2)(B).

1 "(C) FINAL REPORT.—Not later than De-
2 cember 31, 2015, the eligible entity shall sub-
3 mit a report to the Secretary demonstrating im-
4 provements (if any) in each of the areas speci-
5 fied in subparagraph (A).
6 "(2) IMPROVEMENTS IN OUTCOMES FOR INDI-
7 VIDUAL FAMILIES.—
8 "(A) IN GENERAL.—The program is de-
9 signed, with respect to an eligible family partici-
10 pating in the program, to result in the partici-
11 pant outcomes described in subparagraph (B)
12 that the eligible entity identifies on the basis of
13 an individualized assessment of the family, are
14 relevant for that family.
15 "(B) PARTICIPANT OUTCOMES.—The par-
16 ticipant outcomes described in this subpara-
17 graph are the following:
18 "(i) Improvements in prenatal, mater-
19 nal, and newborn health, including im-
20 proved pregnancy outcomes
21 "(ii) Improvements in child health
22 and development, including the prevention
23 of child injuries and maltreatment and im-
24 provements in cognitive, language, social-

emotional, and physical developmental indicators.

"(iii) Improvements in parenting skills.

"(iv) Improvements in school readiness and child academic achievement.

"(v) Reductions in crime or domestic violence.

"(vi) Improvements in family economic self-sufficiency.

"(vii) Improvements in the coordination of referrals for, and the provision of, other community resources and supports for eligible families, consistent with State child welfare agency training.

"(3) CORE COMPONENTS.—The program includes the following core components:

"(A) SERVICE DELIVERY MODEL OR MODELS.—

"(i) IN GENERAL.—Subject to clause (ii), the program is conducted using 1 or more of the service delivery models described in item (aa) or (bb) of subclause (I) or in subclause (II) selected by the eligible entity:

"(I) The model conforms to a clear consistent home visitation model that has been in existence for at least 3 years and is research-based, grounded in relevant empirically-based knowledge, linked to program determined outcomes, associated with a national organization or institution of higher education that has comprehensive home visitation program standards that ensure high quality service delivery and continuous program quality improvement, and has demonstrated significant, (and in the case of the service delivery model described in item (aa), sustained) positive outcomes, as described in the benchmark areas specified in paragraph (1)(A) and the participant outcomes described in paragraph (2)(B), when evaluated using well-designed and rigorous—

"(aa) randomized controlled research designs, and the evalua-

tion results have been published in a peer-reviewed journal; or

"(bb) quasi-experimental research designs.

"(II) The model conforms to a promising and new approach to achieving the benchmark areas specified in paragraph (1)(A) and the participant outcomes described in paragraph (2)(B), has been developed or identified by a national organization or institution of higher education, and will be evaluated through well-designed and rigorous process.

"(ii) MAJORITY OF GRANT FUNDS USED FOR EVIDENCE-BASED MODELS.—An eligible entity shall use not more than 25 percent of the amount of the grant paid to the entity for a fiscal year for purposes of conducting a program using the service delivery model described in clause (i)(II).

"(iii) CRITERIA FOR EVIDENCE OF EFFECTIVENESS OF MODELS.—The Secretary shall establish criteria for evidence of effectiveness of the service delivery models and

shall ensure that the process for establishing the criteria is transparent and provides the opportunity for public comment.

"(B) ADDITIONAL REQUIREMENTS.—

"(i) The program adheres to a clear, consistent model that satisfies the requirements of being grounded in empirically-based knowledge related to home visiting and linked to the benchmark areas specified in paragraph (1)(A) and the participant outcomes described in paragraph (2)(B) related to the purposes of the program.

"(ii) The program employs well-trained and competent staff, as demonstrated by education or training, such as nurses, social workers, educators, child development specialists, or other well-trained and competent staff, and provides ongoing and specific training on the model being delivered.

"(iii) The program maintains high quality supervision to establish home visitor competencies.

"(iv) The program demonstrates strong organizational capacity to implement the activities involved.

"(v) The program establishes appropriate linkages and referral networks to other community resources and supports for eligible families.

"(vi) The program monitors the fidelity of program implementation to ensure that services are delivered pursuant to the specified model.

"(4) PRIORITY FOR SERVING HIGH-RISK POPULATIONS.—The eligible entity gives priority to providing services under the program to the following:

"(A) Eligible families who reside in communities in need of such services, as identified in the statewide needs assessment required under subsection (b)(1)(A).

"(B) Low-income eligible families.

"(C) Eligible families who are pregnant women who have not attained age 21.

"(D) Eligible families that have a history of child abuse or neglect or have had interactions with child welfare services.

"(E) Eligible families that have a history of substance abuse or need substance abuse treatment.

"(F) Eligible families that have users of tobacco products in the home.

"(G) Eligible families that are or have children with low student achievement.

"(H) Eligible families with children with developmental delays or disabilities.

"(I) Eligible families who, or that include individuals who, are serving or formerly served in the Armed Forces, including such families that have members of the Armed Forces who have had multiple deployments outside of the United States.

"(e) APPLICATION REQUIREMENTS.—An eligible entity desiring a grant under this section shall submit an application to the Secretary for approval, in such manner as the Secretary may require, that includes the following:

"(1) A description of the populations to be served by the entity, including specific information regarding how the entity will serve high risk populations described in subsection (d)(4).

"(2) An assurance that the entity will give priority to serving low-income eligible families and eligi-

ble families who reside in at risk communities identified in the statewide needs assessment required under subsection (b)(1)(A).

''(3) The service delivery model or models described in subsection (d)(3)(A) that the entity will use under the program and the basis for the selection of the model or models.

''(4) A statement identifying how the selection of the populations to be served and the service delivery model or models that the entity will use under the program for such populations is consistent with the results of the statewide needs assessment conducted under subsection (b).

''(5) The quantifiable, measurable benchmarks established by the State to demonstrate that the program contributes to improvements in the areas specified in subsection (d)(1)(A).

''(6) An assurance that the entity will obtain and submit documentation or other appropriate evidence from the organization or entity that developed the service delivery model or models used under the program to verify that the program is implemented and services are delivered according to the model specifications.

"(7) Assurances that the entity will establish procedures to ensure that—

"(A) the participation of each eligible family in the program is voluntary; and

"(B) services are provided to an eligible family in accordance with the individual assessment for that family.

"(8) Assurances that the entity will—

"(A) submit annual reports to the Secretary regarding the program and activities carried out under the program that include such information and data as the Secretary shall require; and

"(B) participate in, and cooperate with, data and information collection necessary for the evaluation required under subsection (g)(2) and other research and evaluation activities carried out under subsection (h)(3).

"(9) A description of other State programs that include home visitation services, including, if applicable to the State, other programs carried out under this title with funds made available from allotments under section 502(c), programs funded under title IV, title II of the Child Abuse Prevention and Treatment Act (relating to community-based grants for

the prevention of child abuse and neglect), and section 645A of the Head Start Act (relating to Early Head Start programs).

"(10) Other information as required by the Secretary.

"(f) MAINTENANCE OF EFFORT.—Funds provided to an eligible entity receiving a grant under this section shall supplement, and not supplant, funds from other sources for early childhood home visitation programs or initiatives.

"(g) EVALUATION.—

"(1) INDEPENDENT, EXPERT ADVISORY PANEL.—The Secretary, in accordance with subsection (h)(1)(A), shall appoint an independent advisory panel consisting of experts in program evaluation and research, education, and early childhood development—

"(A) to review, and make recommendations on, the design and plan for the evaluation required under paragraph (2) within 1 year after the date of enactment of this section;

"(B) to maintain and advise the Secretary regarding the progress of the evaluation; and

"(C) to comment, if the panel so desires, on the report submitted under paragraph (3).

"(2) AUTHORITY TO CONDUCT EVALUATION.—On the basis of the recommendations of the advisory panel under paragraph (1), the Secretary shall, by grant, contract, or interagency agreement, conduct an evaluation of the statewide needs assessments submitted under subsection (b) and the grants made under subsections (c) and (h)(3)(B). The evaluation shall include—

"(A) an analysis, on a State-by-State basis, of the results of such assessments, including indicators of maternal and prenatal health and infant health and mortality, and State actions in response to the assessments; and

"(B) an assessment of—

"(i) the effect of early childhood home visitation programs on child and parent outcomes, including with respect to each of the benchmark areas specified in subsection (d)(1)(A) and the participant outcomes described in subsection (d)(2)(B);

"(ii) the effectiveness of such programs on different populations, including the extent to which the ability of programs

to improve participant outcomes varies across programs and populations; and

"(iii) the potential for the activities conducted under such programs, if scaled broadly, to improve health care practices, eliminate health disparities, and improve health care system quality, efficiencies, and reduce costs.

"(3) REPORT.—Not later than March 31, 2015, the Secretary shall submit a report to Congress on the results of the evaluation conducted under paragraph (2) and shall make the report publicly available.

"(h) OTHER PROVISIONS.—

"(1) INTRA-AGENCY COLLABORATION.—The Secretary shall ensure that the Maternal and Child Health Bureau and the Administration for Children and Families collaborate with respect to carrying out this section, including with respect to—

"(A) reviewing and analyzing the statewide needs assessments required under subsection (b), the awarding and oversight of grants awarded under this section, the establishment of the advisory panels required under subsections (d)(1)(B)(iii)(II) and (g)(1), and the

evaluation and report required under subsection (g); and

"(B) consulting with other Federal agencies with responsibility for administering or evaluating programs that serve eligible families to coordinate and collaborate with respect to research related to such programs and families, including the Office of the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services, the Centers for Disease Control and Prevention, the National Institute of Child Health and Human Development of the National Institutes of Health, the Office of Juvenile Justice and Delinquency Prevention of the Department of Justice, and the Institute of Education Sciences of the Department of Education.

"(2) GRANTS TO ELIGIBLE ENTITIES THAT ARE NOT STATES.—

"(A) INDIAN TRIBES, TRIBAL ORGANIZATIONS, OR URBAN INDIAN ORGANIZATIONS.—The Secretary shall specify requirements for eligible entities that are Indian Tribes (or a consortium of Indian Tribes), Tribal Organizations, or Urban Indian Organizations to apply

for and conduct an early childhood home visitation program with a grant under this section. Such requirements shall, to the greatest extent practicable, be consistent with the requirements applicable to eligible entities that are States and shall require an Indian Tribe (or consortium), Tribal Organization, or Urban Indian Organization to—

"(i) conduct a needs assessment similar to the assessment required for all States under subsection (b); and

"(ii) establish quantifiable, measurable 3- and 5-year benchmarks consistent with subsection (d)(1)(A).

"(B) NONPROFIT ORGANIZATIONS.—If, as of the beginning of fiscal year 2012, a State has not applied or been approved for a grant under this section, the Secretary may use amounts appropriated under paragraph (1) of subsection (j) that are available for expenditure under paragraph (3) of that subsection to make a grant to an eligible entity that is a nonprofit organization described in subsection (k)(1)(B) to conduct an early childhood home visitation program in the State. The Secretary shall speci-

fy the requirements for such an organization to apply for and conduct the program which shall, to the greatest extent practicable, be consistent with the requirements applicable to eligible entities that are States and shall require the organization to—

"(i) carry out the program based on the needs assessment conducted by the State under subsection (b); and

"(ii) establish quantifiable, measurable 3- and 5-year benchmarks consistent with subsection (d)(1)(A).

"(3) RESEARCH AND OTHER EVALUATION ACTIVITIES.—

"(A) IN GENERAL.—The Secretary shall carry out a continuous program of research and evaluation activities in order to increase knowledge about the implementation and effectiveness of home visiting programs, using random assignment designs to the maximum extent feasible. The Secretary may carry out such activities directly, or through grants, cooperative agreements, or contracts.

"(B) REQUIREMENTS.—The Secretary shall ensure that—

"(i) evaluation of a specific program or project is conducted by persons or individuals not directly involved in the operation of such program or project; and

"(ii) the conduct of research and evaluation activities includes consultation with independent researchers, State officials, and developers and providers of home visiting programs on topics including research design and administrative data matching.

"(4) REPORT AND RECOMMENDATION.—Not later than December 31, 2015, the Secretary shall submit a report to Congress regarding the programs conducted with grants under this section. The report required under this paragraph shall include—

"(A) information regarding the extent to which eligible entities receiving grants under this section demonstrated improvements in each of the areas specified in subsection (d)(1)(A);

"(B) information regarding any technical assistance provided under subsection (d)(1)(B)(iii)(I), including the type of any such assistance provided; and

"(C) recommendations for such legislative or administrative action as the Secretary determines appropriate.

"(i) APPLICATION OF OTHER PROVISIONS OF TITLE.—

"(1) IN GENERAL.—Except as provided in paragraph (2), the other provisions of this title shall not apply to a grant made under this section.

"(2) EXCEPTIONS.—The following provisions of this title shall apply to a grant made under this section to the same extent and in the same manner as such provisions apply to allotments made under section 502(c):

"(A) Section 504(b)(6) (relating to prohibition on payments to excluded individuals and entities).

"(B) Section 504(c) (relating to the use of funds for the purchase of technical assistance).

"(C) Section 504(d) (relating to a limitation on administrative expenditures).

"(D) Section 506 (relating to reports and audits), but only to the extent determined by the Secretary to be appropriate for grants made under this section.

"(E) Section 507 (relating to penalties for false statements).

"(F) Section 508 (relating to non-discrimination).

"(G) Section 509(a) (relating to the administration of the grant program).

"(j) APPROPRIATIONS.—

"(1) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary to carry out this section—

"(A) $100,000,000 for fiscal year 2010;

"(B) $250,000,000 for fiscal year 2011;

"(C) $350,000,000 for fiscal year 2012;

"(D) $400,000,000 for fiscal year 2013; and

"(E) $400,000,000 for fiscal year 2014.

"(2) RESERVATIONS.—Of the amount appropriated under this subsection for a fiscal year, the Secretary shall reserve—

"(A) 3 percent of such amount for purposes of making grants to eligible entities that are Indian Tribes (or a consortium of Indian Tribes), Tribal Organizations, or Urban Indian Organizations; and

"(B) 3 percent of such amount for purposes of carrying out subsections (d)(1)(B)(iii), (g), and (h)(3).

"(3) AVAILABILITY.—Funds made available to an eligible entity under this section for a fiscal year shall remain available for expenditure by the eligible entity through the end of the second succeeding fiscal year after award. Any funds that are not expended by the eligible entity during the period in which the funds are available under the preceding sentence may be used for grants to nonprofit organizations under subsection (h)(2)(B).

"(k) DEFINITIONS.—In this section:

"(1) ELIGIBLE ENTITY.—

"(A) IN GENERAL.—The term 'eligible entity' means a State, an Indian Tribe, Tribal Organization, or Urban Indian Organization, Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, and American Samoa.

"(B) NONPROFIT ORGANIZATIONS.—Only for purposes of awarding grants under subsection (h)(2)(B), such term shall include a nonprofit organization with an established record of providing early childhood home visita-

tion programs or initiatives in a State or several States.

"(2) ELIGIBLE FAMILY.—The term 'eligible family' means—

"(A) a woman who is pregnant, and the father of the child if the father is available; or

"(B) a parent or primary caregiver of a child, including grandparents or other relatives of the child, and foster parents, who are serving as the child's primary caregiver from birth to kindergarten entry, and including a noncustodial parent who has an ongoing relationship with, and at times provides physical care for, the child.

"(3) INDIAN TRIBE; TRIBAL ORGANIZATION.—The terms 'Indian Tribe' and 'Tribal Organization', and 'Urban Indian Organization' have the meanings given such terms in section 4 of the Indian Health Care Improvement Act.".

SEC. 2952. SUPPORT, EDUCATION, AND RESEARCH FOR POSTPARTUM DEPRESSION.

(a) RESEARCH ON POSTPARTUM CONDITIONS.—

(1) EXPANSION AND INTENSIFICATION OF ACTIVITIES.—The Secretary of Health and Human Services (in this subsection and subsection (c) re-

1 ferred to as the ''Secretary'') is encouraged to con-
2 tinue activities on postpartum depression or
3 postpartum psychosis (in this subsection and sub-
4 section (c) referred to as ''postpartum conditions''),
5 including research to expand the understanding of
6 the causes of, and treatments for, postpartum condi-
7 tions. Activities under this paragraph shall include
8 conducting and supporting the following:
9 (A) Basic research concerning the etiology
10 and causes of the conditions.
11 (B) Epidemiological studies to address the
12 frequency and natural history of the conditions
13 and the differences among racial and ethnic
14 groups with respect to the conditions.
15 (C) The development of improved screen-
16 ing and diagnostic techniques.
17 (D) Clinical research for the development
18 and evaluation of new treatments.
19 (E) Information and education programs
20 for health care professionals and the public,
21 which may include a coordinated national cam-
22 paign to increase the awareness and knowledge
23 of postpartum conditions. Activities under such
24 a national campaign may—

(i) include public service announcements through television, radio, and other means; and

(ii) focus on—

(I) raising awareness about screening;

(II) educating new mothers and their families about postpartum conditions to promote earlier diagnosis and treatment; and

(III) ensuring that such education includes complete information concerning postpartum conditions, including its symptoms, methods of coping with the illness, and treatment resources.

(2) SENSE OF CONGRESS REGARDING LONGITUDINAL STUDY OF RELATIVE MENTAL HEALTH CONSEQUENCES FOR WOMEN OF RESOLVING A PREGNANCY.—

(A) SENSE OF CONGRESS.—It is the sense of Congress that the Director of the National Institute of Mental Health may conduct a nationally representative longitudinal study (during the period of fiscal years 2010 through

2019) of the relative mental health consequences for women of resolving a pregnancy (intended and unintended) in various ways, including carrying the pregnancy to term and parenting the child, carrying the pregnancy to term and placing the child for adoption, miscarriage, and having an abortion. This study may assess the incidence, timing, magnitude, and duration of the immediate and long-term mental health consequences (positive or negative) of these pregnancy outcomes.

(B) REPORT.—Subject to the completion of the study under subsection (a), beginning not later than 5 years after the date of the enactment of this Act, and periodically thereafter for the duration of the study, such Director may prepare and submit to the Congress reports on the findings of the study.

(b) GRANTS TO PROVIDE SERVICES TO INDIVIDUALS WITH A POSTPARTUM CONDITION AND THEIR FAMILIES.—Title V of the Social Security Act (42 U.S.C. 701 et seq.), as amended by section 2951, is amended by adding at the end the following new section:

"SEC. 512. SERVICES TO INDIVIDUALS WITH A POSTPARTUM CONDITION AND THEIR FAMILIES.

"(a) IN GENERAL.—In addition to any other payments made under this title to a State, the Secretary may make grants to eligible entities for projects for the establishment, operation, and coordination of effective and cost-efficient systems for the delivery of essential services to individuals with or at risk for postpartum conditions and their families.

"(b) CERTAIN ACTIVITIES.—To the extent practicable and appropriate, the Secretary shall ensure that projects funded under subsection (a) provide education and services with respect to the diagnosis and management of postpartum conditions for individuals with or at risk for postpartum conditions and their families. The Secretary may allow such projects to include the following:

"(1) Delivering or enhancing outpatient and home-based health and support services, including case management and comprehensive treatment services.

"(2) Delivering or enhancing inpatient care management services that ensure the well-being of the mother and family and the future development of the infant.

1 "(3) Improving the quality, availability, and or-
2 ganization of health care and support services (in-
3 cluding transportation services, attendant care,
4 homemaker services, day or respite care, and pro-
5 viding counseling on financial assistance and insur-
6 ance).
7 "(4) Providing education about postpartum
8 conditions to promote earlier diagnosis and treat-
9 ment. Such education may include—
10 "(A) providing complete information on
11 postpartum conditions, symptoms, methods of
12 coping with the illness, and treatment re-
13 sources; and
14 "(B) in the case of a grantee that is a
15 State, hospital, or birthing facility—
16 "(i) providing education to new moth-
17 ers and fathers, and other family members
18 as appropriate, concerning postpartum
19 conditions before new mothers leave the
20 health facility; and
21 "(ii) ensuring that training programs
22 regarding such education are carried out
23 at the health facility.
24 "(c) INTEGRATION WITH OTHER PROGRAMS.—To
25 the extent practicable and appropriate, the Secretary may

1 integrate the grant program under this section with other
2 grant programs carried out by the Secretary, including the
3 program under section 330 of the Public Health Service
4 Act.

5 "(d) REQUIREMENTS.—The Secretary shall establish
6 requirements for grants made under this section that in-
7 clude a limit on the amount of grants funds that may be
8 used for administration, accounting, reporting, or program
9 oversight functions and a requirement for each eligible en-
10 tity that receives a grant to submit, for each grant period,
11 a report to the Secretary that describes how grant funds
12 were used during such period.

13 "(e) TECHNICAL ASSISTANCE.—The Secretary may
14 provide technical assistance to entities seeking a grant
15 under this section in order to assist such entities in com-
16 plying with the requirements of this section.

17 "(f) APPLICATION OF OTHER PROVISIONS OF
18 TITLE.—

19 "(1) IN GENERAL.—Except as provided in para-
20 graph (2), the other provisions of this title shall not
21 apply to a grant made under this section.

22 "(2) EXCEPTIONS.—The following provisions of
23 this title shall apply to a grant made under this sec-
24 tion to the same extent and in the same manner as

1 such provisions apply to allotments made under sec-
2 tion 502(c):
3 "(A) Section 504(b)(6) (relating to prohi-
4 bition on payments to excluded individuals and
5 entities).
6 "(B) Section 504(c) (relating to the use of
7 funds for the purchase of technical assistance).
8 "(C) Section 504(d) (relating to a limita-
9 tion on administrative expenditures).
10 "(D) Section 506 (relating to reports and
11 audits), but only to the extent determined by
12 the Secretary to be appropriate for grants made
13 under this section.
14 "(E) Section 507 (relating to penalties for
15 false statements).
16 "(F) Section 508 (relating to non-
17 discrimination).
18 "(G) Section 509(a) (relating to the ad-
19 ministration of the grant program).
20 "(g) DEFINITIONS.—In this section:
21 "(1) The term 'eligible entity'—
22 "(A) means a public or nonprofit private
23 entity; and
24 "(B) includes a State or local government,
25 public-private partnership, recipient of a grant

under section 330H of the Public Health Service Act (relating to the Healthy Start Initiative), public or nonprofit private hospital, community-based organization, hospice, ambulatory care facility, community health center, migrant health center, public housing primary care center, or homeless health center.

''(2) The term 'postpartum condition' means postpartum depression or postpartum psychosis.''.

(c) GENERAL PROVISIONS.—

(1) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section and the amendment made by subsection (b), there are authorized to be appropriated, in addition to such other sums as may be available for such purpose—

(A) $3,000,000 for fiscal year 2010; and

(B) such sums as may be necessary for fiscal years 2011 and 2012.

(2) REPORT BY THE SECRETARY.—

(A) STUDY.—The Secretary shall conduct a study on the benefits of screening for postpartum conditions.

(B) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall complete the study required by sub-

paragraph (A) and submit a report to the Congress on the results of such study.

SEC. 2953. PERSONAL RESPONSIBILITY EDUCATION.

Title V of the Social Security Act (42 U.S.C. 701 et seq.), as amended by sections 2951 and 2952(c), is amended by adding at the end the following:

"SEC. 513. PERSONAL RESPONSIBILITY EDUCATION.

"(a) ALLOTMENTS TO STATES.—

"(1) AMOUNT.—

"(A) IN GENERAL.—For the purpose described in subsection (b), subject to the succeeding provisions of this section, for each of fiscal years 2010 through 2014, the Secretary shall allot to each State an amount equal to the product of—

"(i) the amount appropriated under subsection (f) for the fiscal year and available for allotments to States after the application of subsection (c); and

"(ii) the State youth population percentage determined under paragraph (2).

"(B) MINIMUM ALLOTMENT.—

"(i) IN GENERAL.—Each State allotment under this paragraph for a fiscal year shall be at least $250,000.

"(ii) PRO RATA ADJUSTMENTS.—The Secretary shall adjust on a pro rata basis the amount of the State allotments determined under this paragraph for a fiscal year to the extent necessary to comply with clause (i).

"(C) APPLICATION REQUIRED TO ACCESS ALLOTMENTS.—

"(i) IN GENERAL.—A State shall not be paid from its allotment for a fiscal year unless the State submits an application to the Secretary for the fiscal year and the Secretary approves the application (or requires changes to the application that the State satisfies) and meets such additional requirements as the Secretary may specify.

"(ii) REQUIREMENTS.—The State application shall contain an assurance that the State has complied with the requirements of this section in preparing and submitting the application and shall include the following as well as such additional information as the Secretary may require:

"(I) Based on data from the Centers for Disease Control and Pre-

1 vention National Center for Health
2 Statistics, the most recent pregnancy
3 rates for the State for youth ages 10
4 to 14 and youth ages 15 to 19 for
5 which data are available, the most re-
6 cent birth rates for such youth popu-
7 lations in the State for which data are
8 available, and trends in those rates
9 for the most recently preceding 5-year
10 period for which such data are avail-
11 able.
12 ''(II) State-established goals for
13 reducing the pregnancy rates and
14 birth rates for such youth populations.
15 ''(III) A description of the
16 State's plan for using the State allot-
17 ments provided under this section to
18 achieve such goals, especially among
19 youth populations that are the most
20 high-risk or vulnerable for pregnancies
21 or otherwise have special cir-
22 cumstances, including youth in foster
23 care, homeless youth, youth with HIV/
24 AIDS, pregnant youth who are under
25 21 years of age, mothers who are

under 21 years of age, and youth residing in areas with high birth rates for youth.

"(2) STATE YOUTH POPULATION PERCENTAGE.—

"(A) IN GENERAL.—For purposes of paragraph (1)(A)(ii), the State youth population percentage is, with respect to a State, the proportion (expressed as a percentage) of—

"(i) the number of individuals who have attained age 10 but not attained age 20 in the State; to

"(ii) the number of such individuals in all States.

"(B) DETERMINATION OF NUMBER OF YOUTH.—The number of individuals described in clauses (i) and (ii) of subparagraph (A) in a State shall be determined on the basis of the most recent Bureau of the Census data.

"(3) AVAILABILITY OF STATE ALLOTMENTS.—Subject to paragraph (4)(A), amounts allotted to a State pursuant to this subsection for a fiscal year shall remain available for expenditure by the State through the end of the second succeeding fiscal year.

"(4) AUTHORITY TO AWARD GRANTS FROM STATE ALLOTMENTS TO LOCAL ORGANIZATIONS AND ENTITIES IN NONPARTICIPATING STATES.—

"(A) GRANTS FROM UNEXPENDED ALLOTMENTS.—If a State does not submit an application under this section for fiscal year 2010 or 2011, the State shall no longer be eligible to submit an application to receive funds from the amounts allotted for the State for each of fiscal years 2010 through 2014 and such amounts shall be used by the Secretary to award grants under this paragraph for each of fiscal years 2012 through 2014. The Secretary also shall use any amounts from the allotments of States that submit applications under this section for a fiscal year that remain unexpended as of the end of the period in which the allotments are available for expenditure under paragraph (3) for awarding grants under this paragraph.

"(B) 3-YEAR GRANTS.—

"(i) IN GENERAL.—The Secretary shall solicit applications to award 3-year grants in each of fiscal years 2012, 2013, and 2014 to local organizations and entities to conduct, consistent with subsection

(b), programs and activities in States that do not submit an application for an allotment under this section for fiscal year 2010 or 2011.

"(ii) FAITH-BASED ORGANIZATIONS OR CONSORTIA.—The Secretary may solicit and award grants under this paragraph to faith-based organizations or consortia.

"(C) EVALUATION.—An organization or entity awarded a grant under this paragraph shall agree to participate in a rigorous Federal evaluation.

"(5) MAINTENANCE OF EFFORT.—No payment shall be made to a State from the allotment determined for the State under this subsection or to a local organization or entity awarded a grant under paragraph (4), if the expenditure of non-federal funds by the State, organization, or entity for activities, programs, or initiatives for which amounts from allotments and grants under this subsection may be expended is less than the amount expended by the State, organization, or entity for such programs or initiatives for fiscal year 2009.

"(6) DATA COLLECTION AND REPORTING.—A State or local organization or entity receiving funds

1 under this section shall cooperate with such require-
2 ments relating to the collection of data and informa-
3 tion and reporting on outcomes regarding the pro-
4 grams and activities carried out with such funds, as
5 the Secretary shall specify.
6 ''(b) PURPOSE.—
7 ''(1) IN GENERAL.—The purpose of an allot-
8 ment under subsection (a)(1) to a State is to enable
9 the State (or, in the case of grants made under sub-
10 section (a)(4)(B), to enable a local organization or
11 entity) to carry out personal responsibility education
12 programs consistent with this subsection.
13 ''(2) PERSONAL RESPONSIBILITY EDUCATION
14 PROGRAMS.—
15 ''(A) IN GENERAL.—In this section, the
16 term 'personal responsibility education pro-
17 gram' means a program that is designed to
18 educate adolescents on—
19 ''(i) both abstinence and contraception
20 for the prevention of pregnancy and sexu-
21 ally transmitted infections, including HIV/
22 AIDS, consistent with the requirements of
23 subparagraph (B); and

1 "(ii) at least 3 of the adulthood prep-
2 aration subjects described in subparagraph
3 (C).
4 "(B) REQUIREMENTS.—The requirements
5 of this subparagraph are the following:
6 "(i) The program replicates evidence-
7 based effective programs or substantially
8 incorporates elements of effective programs
9 that have been proven on the basis of rig-
10 orous scientific research to change behav-
11 ior, which means delaying sexual activity,
12 increasing condom or contraceptive use for
13 sexually active youth, or reducing preg-
14 nancy among youth.
15 "(ii) The program is medically-accu-
16 rate and complete.
17 "(iii) The program includes activities
18 to educate youth who are sexually active
19 regarding responsible sexual behavior with
20 respect to both abstinence and the use of
21 contraception.
22 "(iv) The program places substantial
23 emphasis on both abstinence and contra-
24 ception for the prevention of pregnancy

among youth and sexually transmitted infections.

"(v) The program provides age-appropriate information and activities.

"(vi) The information and activities carried out under the program are provided in the cultural context that is most appropriate for individuals in the particular population group to which they are directed.

"(C) ADULTHOOD PREPARATION SUBJECTS.—The adulthood preparation subjects described in this subparagraph are the following:

"(i) Healthy relationships, such as positive self-esteem and relationship dynamics, friendships, dating, romantic involvement, marriage, and family interactions.

"(ii) Adolescent development, such as the development of healthy attitudes and values about adolescent growth and development, body image, racial and ethnic diversity, and other related subjects.

"(iii) Financial literacy.

"(iv) Parent-child communication.

"(v) Educational and career success, such as developing skills for employment preparation, job seeking, independent living, financial self-sufficiency, and workplace productivity.

"(vi) Healthy life skills, such as goal-setting, decision making, negotiation, communication and interpersonal skills, and stress management.

"(c) RESERVATIONS OF FUNDS.—

"(1) GRANTS TO IMPLEMENT INNOVATIVE STRATEGIES.—From the amount appropriated under subsection (f) for the fiscal year, the Secretary shall reserve $10,000,000 of such amount for purposes of awarding grants to entities to implement innovative youth pregnancy prevention strategies and target services to high-risk, vulnerable, and culturally under-represented youth populations, including youth in foster care, homeless youth, youth with HIV/AIDS, pregnant women who are under 21 years of age and their partners, mothers who are under 21 years of age and their partners, and youth residing in areas with high birth rates for youth. An entity awarded a grant under this paragraph shall agree to

1 participate in a rigorous Federal evaluation of the
2 activities carried out with grant funds.
3 "(2) OTHER RESERVATIONS.—From the
4 amount appropriated under subsection (f) for the
5 fiscal year that remains after the application of
6 paragraph (1), the Secretary shall reserve the fol-
7 lowing amounts:
8 "(A) GRANTS FOR INDIAN TRIBES OR
9 TRIBAL ORGANIZATIONS.—The Secretary shall
10 reserve 5 percent of such remainder for pur-
11 poses of awarding grants to Indian tribes and
12 tribal organizations in such manner, and sub-
13 ject to such requirements, as the Secretary, in
14 consultation with Indian tribes and tribal orga-
15 nizations, determines appropriate.
16 "(B) SECRETARIAL RESPONSIBILITIES.—
17 "(i) RESERVATION OF FUNDS.—The
18 Secretary shall reserve 10 percent of such
19 remainder for expenditures by the Sec-
20 retary for the activities described in
21 clauses (ii) and (iii).
22 "(ii) PROGRAM SUPPORT.—The Sec-
23 retary shall provide, directly or through a
24 competitive grant process, research, train-
25 ing and technical assistance, including dis-

1 semination of research and information re-
2 garding effective and promising practices,
3 providing consultation and resources on a
4 broad array of teen pregnancy prevention
5 strategies, including abstinence and contra-
6 ception, and developing resources and ma-
7 terials to support the activities of recipi-
8 ents of grants and other State, tribal, and
9 community organizations working to re-
10 duce teen pregnancy. In carrying out such
11 functions, the Secretary shall collaborate
12 with a variety of entities that have exper-
13 tise in the prevention of teen pregnancy,
14 HIV and sexually transmitted infections,
15 healthy relationships, financial literacy,
16 and other topics addressed through the
17 personal responsibility education programs.
18 ''(iii) EVALUATION.—The Secretary
19 shall evaluate the programs and activities
20 carried out with funds made available
21 through allotments or grants under this
22 section.
23 ''(d) ADMINISTRATION.—
24 ''(1) IN GENERAL.—The Secretary shall admin-
25 ister this section through the Assistant Secretary for

the Administration for Children and Families within the Department of Health and Human Services.

"(2) APPLICATION OF OTHER PROVISIONS OF TITLE.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), the other provisions of this title shall not apply to allotments or grants made under this section.

"(B) EXCEPTIONS.—The following provisions of this title shall apply to allotments and grants made under this section to the same extent and in the same manner as such provisions apply to allotments made under section 502(c):

"(i) Section 504(b)(6) (relating to prohibition on payments to excluded individuals and entities).

"(ii) Section 504(c) (relating to the use of funds for the purchase of technical assistance).

"(iii) Section 504(d) (relating to a limitation on administrative expenditures).

"(iv) Section 506 (relating to reports and audits), but only to the extent determined by the Secretary to be appropriate for grants made under this section.

"(v) Section 507 (relating to penalties for false statements).

"(vi) Section 508 (relating to non-discrimination).

"(e) DEFINITIONS.—In this section:

"(1) AGE-APPROPRIATE.—The term 'age-appropriate', with respect to the information in pregnancy prevention, means topics, messages, and teaching methods suitable to particular ages or age groups of children and adolescents, based on developing cognitive, emotional, and behavioral capacity typical for the age or age group.

"(2) MEDICALLY ACCURATE AND COMPLETE.—The term 'medically accurate and complete' means verified or supported by the weight of research conducted in compliance with accepted scientific methods and—

"(A) published in peer-reviewed journals, where applicable; or

"(B) comprising information that leading professional organizations and agencies with relevant expertise in the field recognize as accurate, objective, and complete.

"(3) INDIAN TRIBES; TRIBAL ORGANIZATIONS.—The terms 'Indian tribe' and 'Tribal organi-

1 zation' have the meanings given such terms in sec-
2 tion 4 of the Indian Health Care Improvement Act
3 (25 U.S.C. 1603)).
4 ''(4) YOUTH.—The term 'youth' means an indi-
5 vidual who has attained age 10 but has not attained
6 age 20.
7 ''(f) APPROPRIATION.—For the purpose of carrying
8 out this section, there is appropriated, out of any money
9 in the Treasury not otherwise appropriated, $75,000,000
10 for each of fiscal years 2010 through 2014. Amounts ap-
11 propriated under this subsection shall remain available
12 until expended.''.

13 **SEC. 2954. RESTORATION OF FUNDING FOR ABSTINENCE**
14 **EDUCATION.**

15 Section 510 of the Social Security Act (42 U.S.C.
16 710) is amended—
17 (1) in subsection (a), by striking ''fiscal year
18 1998 and each subsequent fiscal year'' and inserting
19 ''each of fiscal years 2010 through 2014''; and
20 (2) in subsection (d)—
21 (A) in the first sentence, by striking ''1998
22 through 2003'' and inserting ''2010 through
23 2014''; and
24 (B) in the second sentence, by inserting
25 ''(except that such appropriation shall be made

on the date of enactment of the Patient Protection and Affordable Care Act in the case of fiscal year 2010)'' before the period.

SEC. 2955. INCLUSION OF INFORMATION ABOUT THE IMPORTANCE OF HAVING A HEALTH CARE POWER OF ATTORNEY IN TRANSITION PLANNING FOR CHILDREN AGING OUT OF FOSTER CARE AND INDEPENDENT LIVING PROGRAMS.

(a) TRANSITION PLANNING.—Section 475(5)(H) of the Social Security Act (42 U.S.C. 675(5)(H)) is amended by inserting ''includes information about the importance of designating another individual to make health care treatment decisions on behalf of the child if the child becomes unable to participate in such decisions and the child does not have, or does not want, a relative who would otherwise be authorized under State law to make such decisions, and provides the child with the option to execute a health care power of attorney, health care proxy, or other similar document recognized under State law,'' after ''employment services,''.

(b) INDEPENDENT LIVING EDUCATION.—Section 477(b)(3) of such Act (42 U.S.C. 677(b)(3)) is amended by adding at the end the following:

''(K) A certification by the chief executive officer of the State that the State will ensure

that an adolescent participating in the program under this section are provided with education about the importance of designating another individual to make health care treatment decisions on behalf of the adolescent if the adolescent becomes unable to participate in such decisions and the adolescent does not have, or does not want, a relative who would otherwise be authorized under State law to make such decisions, whether a health care power of attorney, health care proxy, or other similar document is recognized under State law, and how to execute such a document if the adolescent wants to do so.''.

(c) HEALTH OVERSIGHT AND COORDINATION PLAN.—Section 422(b)(15)(A) of such Act (42 U.S.C. 622(b)(15)(A)) is amended—

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

(2) by adding at the end the following:

''(vii) steps to ensure that the components of the transition plan development process required under section 475(5)(H) that relate to the health care needs of children aging out of foster care, including the

requirements to include options for health insurance, information about a health care power of attorney, health care proxy, or other similar document recognized under State law, and to provide the child with the option to execute such a document, are met; and''.

(d) EFFECTIVE DATE.—The amendments made by this section take effect on October 1, 2010.

TITLE III—IMPROVING THE QUALITY AND EFFICIENCY OF HEALTH CARE

Subtitle A—Transforming the Health Care Delivery System

PART I—LINKING PAYMENT TO QUALITY OUTCOMES UNDER THE MEDICARE PROGRAM

SEC. 3001. HOSPITAL VALUE-BASED PURCHASING PROGRAM.

(a) PROGRAM.—

(1) IN GENERAL.—Section 1886 of the Social Security Act (42 U.S.C. 1395ww), as amended by section 4102(a) of the HITECH Act (Public Law 111–5), is amended by adding at the end the following new subsection:

1 "(o) HOSPITAL VALUE-BASED PURCHASING PRO-
2 GRAM.—
3 "(1) ESTABLISHMENT.—
4 "(A) IN GENERAL.—Subject to the suc-
5 ceeding provisions of this subsection, the Sec-
6 retary shall establish a hospital value-based
7 purchasing program (in this subsection referred
8 to as the 'Program') under which value-based
9 incentive payments are made in a fiscal year to
10 hospitals that meet the performance standards
11 under paragraph (3) for the performance period
12 for such fiscal year (as established under para-
13 graph (4)).
14 "(B) PROGRAM TO BEGIN IN FISCAL YEAR
15 2013.—The Program shall apply to payments
16 for discharges occurring on or after October 1,
17 2012.
18 "(C) APPLICABILITY OF PROGRAM TO HOS-
19 PITALS.—
20 "(i) IN GENERAL.—For purposes of
21 this subsection, subject to clause (ii), the
22 term 'hospital' means a subsection (d) hos-
23 pital (as defined in subsection (d)(1)(B)).

"(ii) EXCLUSIONS.—The term 'hospital' shall not include, with respect to a fiscal year, a hospital—

"(I) that is subject to the payment reduction under subsection (b)(3)(B)(viii)(I) for such fiscal year;

"(II) for which, during the performance period for such fiscal year, the Secretary has cited deficiencies that pose immediate jeopardy to the health or safety of patients;

"(III) for which there are not a minimum number (as determined by the Secretary) of measures that apply to the hospital for the performance period for such fiscal year; or

"(IV) for which there are not a minimum number (as determined by the Secretary) of cases for the measures that apply to the hospital for the performance period for such fiscal year.

"(iii) INDEPENDENT ANALYSIS.—For purposes of determining the minimum numbers under subclauses (III) and (IV)

of clause (ii), the Secretary shall have conducted an independent analysis of what numbers are appropriate.

"(iv) EXEMPTION.—In the case of a hospital that is paid under section 1814(b)(3), the Secretary may exempt such hospital from the application of this subsection if the State which is paid under such section submits an annual report to the Secretary describing how a similar program in the State for a participating hospital or hospitals achieves or surpasses the measured results in terms of patient health outcomes and cost savings established under this subsection.

"(2) MEASURES.—

"(A) IN GENERAL.—The Secretary shall select measures for purposes of the Program. Such measures shall be selected from the measures specified under subsection (b)(3)(B)(viii).

"(B) REQUIREMENTS.—

"(i) FOR FISCAL YEAR 2013.—For value-based incentive payments made with respect to discharges occurring during fis-

1 cal year 2013, the Secretary shall ensure
2 the following:
3 "(I) CONDITIONS OR PROCE-
4 DURES.—Measures are selected under
5 subparagraph (A) that cover at least
6 the following 5 specific conditions or
7 procedures:
8 "(aa) Acute myocardial in-
9 farction (AMI).
10 "(bb) Heart failure.
11 "(cc) Pneumonia.
12 "(dd) Surgeries, as meas-
13 ured by the Surgical Care Im-
14 provement Project (formerly re-
15 ferred to as 'Surgical Infection
16 Prevention' for discharges occur-
17 ring before July 2006).
18 "(ee) Healthcare-associated
19 infections, as measured by the
20 prevention metrics and targets
21 established in the HHS Action
22 Plan to Prevent Healthcare-Asso-
23 ciated Infections (or any suc-
24 cessor plan) of the Department
25 of Health and Human Services.

1 "(II) HCAHPS.—Measures se-
2 lected under subparagraph (A) shall
3 be related to the Hospital Consumer
4 Assessment of Healthcare Providers
5 and Systems survey (HCAHPS).
6 "(ii) INCLUSION OF EFFICIENCY
7 MEASURES.—For value-based incentive
8 payments made with respect to discharges
9 occurring during fiscal year 2014 or a sub-
10 sequent fiscal year, the Secretary shall en-
11 sure that measures selected under subpara-
12 graph (A) include efficiency measures, in-
13 cluding measures of 'Medicare spending
14 per beneficiary'. Such measures shall be
15 adjusted for factors such as age, sex, race,
16 severity of illness, and other factors that
17 the Secretary determines appropriate.
18 "(C) LIMITATIONS.—
19 "(i) TIME REQUIREMENT FOR PRIOR
20 REPORTING AND NOTICE.—The Secretary
21 may not select a measure under subpara-
22 graph (A) for use under the Program with
23 respect to a performance period for a fiscal
24 year (as established under paragraph (4))
25 unless such measure has been specified

under subsection (b)(3)(B)(viii) and included on the Hospital Compare Internet website for at least 1 year prior to the beginning of such performance period.

"(ii) MEASURE NOT APPLICABLE UNLESS HOSPITAL FURNISHES SERVICES APPROPRIATE TO THE MEASURE.—A measure selected under subparagraph (A) shall not apply to a hospital if such hospital does not furnish services appropriate to such measure.

"(D) REPLACING MEASURES.—Subclause (VI) of subsection (b)(3)(B)(viii) shall apply to measures selected under subparagraph (A) in the same manner as such subclause applies to measures selected under such subsection.

"(3) PERFORMANCE STANDARDS.—

"(A) ESTABLISHMENT.—The Secretary shall establish performance standards with respect to measures selected under paragraph (2) for a performance period for a fiscal year (as established under paragraph (4)).

"(B) ACHIEVEMENT AND IMPROVEMENT.—The performance standards established

1 under subparagraph (A) shall include levels of
2 achievement and improvement.
3 "(C) TIMING.—The Secretary shall estab-
4 lish and announce the performance standards
5 under subparagraph (A) not later than 60 days
6 prior to the beginning of the performance pe-
7 riod for the fiscal year involved.
8 "(D) CONSIDERATIONS IN ESTABLISHING
9 STANDARDS.—In establishing performance
10 standards with respect to measures under this
11 paragraph, the Secretary shall take into ac-
12 count appropriate factors, such as—
13 "(i) practical experience with the
14 measures involved, including whether a sig-
15 nificant proportion of hospitals failed to
16 meet the performance standard during pre-
17 vious performance periods;
18 "(ii) historical performance standards;
19 "(iii) improvement rates; and
20 "(iv) the opportunity for continued
21 improvement.
22 "(4) PERFORMANCE PERIOD.—For purposes of
23 the Program, the Secretary shall establish the per-
24 formance period for a fiscal year. Such performance

period shall begin and end prior to the beginning of such fiscal year.

"(5) HOSPITAL PERFORMANCE SCORE.—

"(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall develop a methodology for assessing the total performance of each hospital based on performance standards with respect to the measures selected under paragraph (2) for a performance period (as established under paragraph (4)). Using such methodology, the Secretary shall provide for an assessment (in this subsection referred to as the 'hospital performance score') for each hospital for each performance period.

"(B) APPLICATION.—

"(i) APPROPRIATE DISTRIBUTION.—The Secretary shall ensure that the application of the methodology developed under subparagraph (A) results in an appropriate distribution of value-based incentive payments under paragraph (6) among hospitals achieving different levels of hospital performance scores, with hospitals achieving the highest hospital performance scores

1 receiving the largest value-based incentive
2 payments.
3 "(ii) HIGHER OF ACHIEVEMENT OR
4 IMPROVEMENT.—The methodology devel-
5 oped under subparagraph (A) shall provide
6 that the hospital performance score is de-
7 termined using the higher of its achieve-
8 ment or improvement score for each meas-
9 ure.
10 "(iii) WEIGHTS.—The methodology
11 developed under subparagraph (A) shall
12 provide for the assignment of weights for
13 categories of measures as the Secretary de-
14 termines appropriate.
15 "(iv) NO MINIMUM PERFORMANCE
16 STANDARD.—The Secretary shall not set a
17 minimum performance standard in deter-
18 mining the hospital performance score for
19 any hospital.
20 "(v) REFLECTION OF MEASURES AP-
21 PLICABLE TO THE HOSPITAL.—The hos-
22 pital performance score for a hospital shall
23 reflect the measures that apply to the hos-
24 pital.

"(6) CALCULATION OF VALUE-BASED INCENTIVE PAYMENTS.—

"(A) IN GENERAL.—In the case of a hospital that the Secretary determines meets (or exceeds) the performance standards under paragraph (3) for the performance period for a fiscal year (as established under paragraph (4)), the Secretary shall increase the base operating DRG payment amount (as defined in paragraph (7)(D)), as determined after application of paragraph (7)(B)(i), for a hospital for each discharge occurring in such fiscal year by the value-based incentive payment amount.

"(B) VALUE-BASED INCENTIVE PAYMENT AMOUNT.—The value-based incentive payment amount for each discharge of a hospital in a fiscal year shall be equal to the product of—

"(i) the base operating DRG payment amount (as defined in paragraph (7)(D)) for the discharge for the hospital for such fiscal year; and

"(ii) the value-based incentive payment percentage specified under subparagraph (C) for the hospital for such fiscal year.

1 "(C) VALUE-BASED INCENTIVE PAYMENT
2 PERCENTAGE.—
3 "(i) IN GENERAL.—The Secretary
4 shall specify a value-based incentive pay-
5 ment percentage for a hospital for a fiscal
6 year.
7 "(ii) REQUIREMENTS.—In specifying
8 the value-based incentive payment percent-
9 age for each hospital for a fiscal year
10 under clause (i), the Secretary shall ensure
11 that—
12 "(I) such percentage is based on
13 the hospital performance score of the
14 hospital under paragraph (5); and
15 "(II) the total amount of value-
16 based incentive payments under this
17 paragraph to all hospitals in such fis-
18 cal year is equal to the total amount
19 available for value-based incentive
20 payments for such fiscal year under
21 paragraph (7)(A), as estimated by the
22 Secretary.
23 "(7) FUNDING FOR VALUE-BASED INCENTIVE
24 PAYMENTS.—

"(A) AMOUNT.—The total amount available for value-based incentive payments under paragraph (6) for all hospitals for a fiscal year shall be equal to the total amount of reduced payments for all hospitals under subparagraph (B) for such fiscal year, as estimated by the Secretary.

"(B) ADJUSTMENT TO PAYMENTS.—

"(i) IN GENERAL.—The Secretary shall reduce the base operating DRG payment amount (as defined in subparagraph (D)) for a hospital for each discharge in a fiscal year (beginning with fiscal year 2013) by an amount equal to the applicable percent (as defined in subparagraph (C)) of the base operating DRG payment amount for the discharge for the hospital for such fiscal year. The Secretary shall make such reductions for all hospitals in the fiscal year involved, regardless of whether or not the hospital has been determined by the Secretary to have earned a value-based incentive payment under paragraph (6) for such fiscal year.

"(ii) NO EFFECT ON OTHER PAYMENTS.—Payments described in items (aa) and (bb) of subparagraph (D)(i)(II) for a hospital shall be determined as if this subsection had not been enacted.

"(C) APPLICABLE PERCENT DEFINED.—For purposes of subparagraph (B), the term 'applicable percent' means—

"(i) with respect to fiscal year 2013, 1.0 percent;

"(ii) with respect to fiscal year 2014, 1.25 percent;

"(iii) with respect to fiscal year 2015, 1.5 percent;

"(iv) with respect to fiscal year 2016, 1.75 percent; and

"(v) with respect to fiscal year 2017 and succeeding fiscal years, 2 percent.

"(D) BASE OPERATING DRG PAYMENT AMOUNT DEFINED.—

"(i) IN GENERAL.—Except as provided in clause (ii), in this subsection, the term 'base operating DRG payment amount' means, with respect to a hospital for a fiscal year—

1 "(I) the payment amount that
2 would otherwise be made under sub-
3 section (d) (determined without re-
4 gard to subsection (q)) for a discharge
5 if this subsection did not apply; re-
6 duced by
7 "(II) any portion of such pay-
8 ment amount that is attributable to—
9 "(aa) payments under para-
10 graphs (5)(A), (5)(B), (5)(F),
11 and (12) of subsection (d); and
12 "(bb) such other payments
13 under subsection (d) determined
14 appropriate by the Secretary.
15 "(ii) SPECIAL RULES FOR CERTAIN
16 HOSPITALS.—
17 "(I) SOLE COMMUNITY HOS-
18 PITALS AND MEDICARE-DEPENDENT,
19 SMALL RURAL HOSPITALS.—In the
20 case of a medicare-dependent, small
21 rural hospital (with respect to dis-
22 charges occurring during fiscal year
23 2012 and 2013) or a sole community
24 hospital, in applying subparagraph
25 (A)(i), the payment amount that

would otherwise be made under subsection (d) shall be determined without regard to subparagraphs (I) and (L) of subsection (b)(3) and subparagraphs (D) and (G) of subsection (d)(5).

"(II) HOSPITALS PAID UNDER SECTION 1814.—In the case of a hospital that is paid under section 1814(b)(3), the term 'base operating DRG payment amount' means the payment amount under such section.

"(8) ANNOUNCEMENT OF NET RESULT OF ADJUSTMENTS.—Under the Program, the Secretary shall, not later than 60 days prior to the fiscal year involved, inform each hospital of the adjustments to payments to the hospital for discharges occurring in such fiscal year under paragraphs (6) and (7)(B)(i).

"(9) NO EFFECT IN SUBSEQUENT FISCAL YEARS.—The value-based incentive payment under paragraph (6) and the payment reduction under paragraph (7)(B)(i) shall each apply only with respect to the fiscal year involved, and the Secretary shall not take into account such value-based incentive payment or payment reduction in making pay-

1 ments to a hospital under this section in a subse-
2 quent fiscal year.
3 "(10) PUBLIC REPORTING.—
4 "(A) HOSPITAL SPECIFIC INFORMATION.—
5 "(i) IN GENERAL.—The Secretary
6 shall make information available to the
7 public regarding the performance of indi-
8 vidual hospitals under the Program, in-
9 cluding—
10 "(I) the performance of the hos-
11 pital with respect to each measure
12 that applies to the hospital;
13 "(II) the performance of the hos-
14 pital with respect to each condition or
15 procedure; and
16 "(III) the hospital performance
17 score assessing the total performance
18 of the hospital.
19 "(ii) OPPORTUNITY TO REVIEW AND
20 SUBMIT CORRECTIONS.—The Secretary
21 shall ensure that a hospital has the oppor-
22 tunity to review, and submit corrections
23 for, the information to be made public with
24 respect to the hospital under clause (i)

prior to such information being made public.

"(iii) WEBSITE.—Such information shall be posted on the Hospital Compare Internet website in an easily understandable format.

"(B) AGGREGATE INFORMATION.—The Secretary shall periodically post on the Hospital Compare Internet website aggregate information on the Program, including—

"(i) the number of hospitals receiving value-based incentive payments under paragraph (6) and the range and total amount of such value-based incentive payments; and

"(ii) the number of hospitals receiving less than the maximum value-based incentive payment available to the hospital for the fiscal year involved and the range and amount of such payments.

"(11) IMPLEMENTATION.—

"(A) APPEALS.—The Secretary shall establish a process by which hospitals may appeal the calculation of a hospital's performance assessment with respect to the performance

1 standards established under paragraph (3)(A)
2 and the hospital performance score under para-
3 graph (5). The Secretary shall ensure that such
4 process provides for resolution of such appeals
5 in a timely manner.

6 ''(B) LIMITATION ON REVIEW.—Except as
7 provided in subparagraph (A), there shall be no
8 administrative or judicial review under section
9 1869, section 1878, or otherwise of the fol-
10 lowing:

11 ''(i) The methodology used to deter-
12 mine the amount of the value-based incen-
13 tive payment under paragraph (6) and the
14 determination of such amount.

15 ''(ii) The determination of the amount
16 of funding available for such value-based
17 incentive payments under paragraph
18 (7)(A) and the payment reduction under
19 paragraph (7)(B)(i).

20 ''(iii) The establishment of the per-
21 formance standards under paragraph (3)
22 and the performance period under para-
23 graph (4).

"(iv) The measures specified under subsection (b)(3)(B)(viii) and the measures selected under paragraph (2).

"(v) The methodology developed under paragraph (5) that is used to calculate hospital performance scores and the calculation of such scores.

"(vi) The validation methodology specified in subsection (b)(3)(B)(viii)(XI).

"(C) CONSULTATION WITH SMALL HOSPITALS.—The Secretary shall consult with small rural and urban hospitals on the application of the Program to such hospitals.

"(12) PROMULGATION OF REGULATIONS.—The Secretary shall promulgate regulations to carry out the Program, including the selection of measures under paragraph (2), the methodology developed under paragraph (5) that is used to calculate hospital performance scores, and the methodology used to determine the amount of value-based incentive payments under paragraph (6).".

(2) AMENDMENTS FOR REPORTING OF HOSPITAL QUALITY INFORMATION.—Section 1886(b)(3)(B)(viii) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(viii)) is amended—

(A) in subclause (II), by adding at the end the following sentence: ''The Secretary may require hospitals to submit data on measures that are not used for the determination of value-based incentive payments under subsection (o).'';

(B) in subclause (V), by striking ''beginning with fiscal year 2008'' and inserting ''for fiscal years 2008 through 2012'';

(C) in subclause (VII), in the first sentence, by striking ''data submitted'' and inserting ''information regarding measures submitted''; and

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

''(VIII) Effective for payments beginning with fiscal year 2013, with respect to quality measures for outcomes of care, the Secretary shall provide for such risk adjustment as the Secretary determines to be appropriate to maintain incentives for hospitals to treat patients with severe illnesses or conditions.

''(IX)(aa) Subject to item (bb), effective for payments beginning with fiscal year 2013, each measure specified by the Secretary under this clause shall be endorsed by the entity with a contract under section 1890(a).

1 "(bb) In the case of a specified area or medical topic
2 determined appropriate by the Secretary for which a fea-
3 sible and practical measure has not been endorsed by the
4 entity with a contract under section 1890(a), the Sec-
5 retary may specify a measure that is not so endorsed as
6 long as due consideration is given to measures that have
7 been endorsed or adopted by a consensus organization
8 identified by the Secretary.

9 "(X) To the extent practicable, the Secretary shall,
10 with input from consensus organizations and other stake-
11 holders, take steps to ensure that the measures specified
12 by the Secretary under this clause are coordinated and
13 aligned with quality measures applicable to—

14 "(aa) physicians under section 1848(k); and

15 "(bb) other providers of services and suppliers
16 under this title.

17 "(XI) The Secretary shall establish a process to vali-
18 date measures specified under this clause as appropriate.
19 Such process shall include the auditing of a number of
20 randomly selected hospitals sufficient to ensure validity of
21 the reporting program under this clause as a whole and
22 shall provide a hospital with an opportunity to appeal the
23 validation of measures reported by such hospital.".

24 (3) WEBSITE IMPROVEMENTS.—Section
25 1886(b)(3)(B) of the Social Security Act (42 U.S.C.

1395ww(b)(3)(B)), as amended by section 4102(b) of the HITECH Act (Public Law 111–5), is amended by adding at the end the following new clause:

''(x)(I) The Secretary shall develop standard Internet website reports tailored to meet the needs of various stakeholders such as hospitals, patients, researchers, and policymakers. The Secretary shall seek input from such stakeholders in determining the type of information that is useful and the formats that best facilitate the use of the information.

''(II) The Secretary shall modify the Hospital Compare Internet website to make the use and navigation of that website readily available to individuals accessing it.''.

(4) GAO STUDY AND REPORT.—

(A) STUDY.—The Comptroller General of the United States shall conduct a study on the performance of the hospital value-based purchasing program established under section 1886(o) of the Social Security Act, as added by paragraph (1). Such study shall include an analysis of the impact of such program on—

(i) the quality of care furnished to Medicare beneficiaries, including diverse Medicare beneficiary populations (such as

1 diverse in terms of race, ethnicity, and so-
2 cioeconomic status);
3 (ii) expenditures under the Medicare
4 program, including any reduced expendi-
5 tures under Part A of title XVIII of such
6 Act that are attributable to the improve-
7 ment in the delivery of inpatient hospital
8 services by reason of such hospital value-
9 based purchasing program;
10 (iii) the quality performance among
11 safety net hospitals and any barriers such
12 hospitals face in meeting the performance
13 standards applicable under such hospital
14 value-based purchasing program; and
15 (iv) the quality performance among
16 small rural and small urban hospitals and
17 any barriers such hospitals face in meeting
18 the performance standards applicable
19 under such hospital value-based purchasing
20 program.
21 (B) REPORTS.—
22 (i) INTERIM REPORT.—Not later than
23 October 1, 2015, the Comptroller General
24 of the United States shall submit to Con-
25 gress an interim report containing the re-

sults of the study conducted under subparagraph (A), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

(ii) FINAL REPORT.—Not later than July 1, 2017, the Comptroller General of the United States shall submit to Congress a report containing the results of the study conducted under subparagraph (A), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

(5) HHS STUDY AND REPORT.—

(A) STUDY.—The Secretary of Health and Human Services shall conduct a study on the performance of the hospital value-based purchasing program established under section 1886(o) of the Social Security Act, as added by paragraph (1). Such study shall include an analysis—

(i) of ways to improve the hospital value-based purchasing program and ways to address any unintended consequences

that may occur as a result of such program;

(ii) of whether the hospital value-based purchasing program resulted in lower spending under the Medicare program under title XVIII of such Act or other financial savings to hospitals;

(iii) the appropriateness of the Medicare program sharing in any savings generated through the hospital value-based purchasing program; and

(iv) any other area determined appropriate by the Secretary.

(B) REPORT.—Not later than January 1, 2016, the Secretary of Health and Human Services shall submit to Congress a report containing the results of the study conducted under subparagraph (A), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

(b) VALUE-BASED PURCHASING DEMONSTRATION PROGRAMS.—

(1) VALUE-BASED PURCHASING DEMONSTRATION PROGRAM FOR INPATIENT CRITICAL ACCESS HOSPITALS.—

1 (A) ESTABLISHMENT.—

2 (i) IN GENERAL.—Not later than 2
3 years after the date of enactment of this
4 Act, the Secretary of Health and Human
5 Services (in this subsection referred to as
6 the ''Secretary'') shall establish a dem-
7 onstration program under which the Sec-
8 retary establishes a value-based purchasing
9 program under the Medicare program
10 under title XVIII of the Social Security
11 Act for critical access hospitals (as defined
12 in paragraph (1) of section 1861(mm) of
13 such Act (42 U.S.C. 1395x(mm))) with re-
14 spect to inpatient critical access hospital
15 services (as defined in paragraph (2) of
16 such section) in order to test innovative
17 methods of measuring and rewarding qual-
18 ity and efficient health care furnished by
19 such hospitals.

20 (ii) DURATION.—The demonstration
21 program under this paragraph shall be
22 conducted for a 3-year period.

23 (iii) SITES.—The Secretary shall con-
24 duct the demonstration program under this
25 paragraph at an appropriate number (as

1 determined by the Secretary) of critical ac-
2 cess hospitals. The Secretary shall ensure
3 that such hospitals are representative of
4 the spectrum of such hospitals that partici-
5 pate in the Medicare program.
6 (B) WAIVER AUTHORITY.—The Secretary
7 may waive such requirements of titles XI and
8 XVIII of the Social Security Act as may be nec-
9 essary to carry out the demonstration program
10 under this paragraph.
11 (C) BUDGET NEUTRALITY REQUIRE-
12 MENT.—In conducting the demonstration pro-
13 gram under this section, the Secretary shall en-
14 sure that the aggregate payments made by the
15 Secretary do not exceed the amount which the
16 Secretary would have paid if the demonstration
17 program under this section was not imple-
18 mented.
19 (D) REPORT.—Not later than 18 months
20 after the completion of the demonstration pro-
21 gram under this paragraph, the Secretary shall
22 submit to Congress a report on the demonstra-
23 tion program together with—
24 (i) recommendations on the establish-
25 ment of a permanent value-based pur-

chasing program under the Medicare program for critical access hospitals with respect to inpatient critical access hospital services; and

(ii) recommendations for such other legislation and administrative action as the Secretary determines appropriate.

(2) VALUE-BASED PURCHASING DEMONSTRATION PROGRAM FOR HOSPITALS EXCLUDED FROM HOSPITAL VALUE-BASED PURCHASING PROGRAM AS A RESULT OF INSUFFICIENT NUMBERS OF MEASURES AND CASES.—

(A) ESTABLISHMENT.—

(i) IN GENERAL.—Not later than 2 years after the date of enactment of this Act, the Secretary shall establish a demonstration program under which the Secretary establishes a value-based purchasing program under the Medicare program under title XVIII of the Social Security Act for applicable hospitals (as defined in clause (ii)) with respect to inpatient hospital services (as defined in section 1861(b) of the Social Security Act (42 U.S.C. 1395x(b))) in order to test innova-

tive methods of measuring and rewarding quality and efficient health care furnished by such hospitals.

(ii) APPLICABLE HOSPITAL DEFINED.—For purposes of this paragraph, the term ''applicable hospital'' means a hospital described in subclause (III) or (IV) of section 1886(o)(1)(C)(ii) of the Social Security Act, as added by subsection (a)(1).

(iii) DURATION.—The demonstration program under this paragraph shall be conducted for a 3-year period.

(iv) SITES.—The Secretary shall conduct the demonstration program under this paragraph at an appropriate number (as determined by the Secretary) of applicable hospitals. The Secretary shall ensure that such hospitals are representative of the spectrum of such hospitals that participate in the Medicare program.

(B) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act as may be nec-

1 essary to carry out the demonstration program
2 under this paragraph.
3 (C) BUDGET NEUTRALITY REQUIRE-
4 MENT.—In conducting the demonstration pro-
5 gram under this section, the Secretary shall en-
6 sure that the aggregate payments made by the
7 Secretary do not exceed the amount which the
8 Secretary would have paid if the demonstration
9 program under this section was not imple-
10 mented.
11 (D) REPORT.—Not later than 18 months
12 after the completion of the demonstration pro-
13 gram under this paragraph, the Secretary shall
14 submit to Congress a report on the demonstra-
15 tion program together with—
16 (i) recommendations on the establish-
17 ment of a permanent value-based pur-
18 chasing program under the Medicare pro-
19 gram for applicable hospitals with respect
20 to inpatient hospital services; and
21 (ii) recommendations for such other
22 legislation and administrative action as the
23 Secretary determines appropriate.

SEC. 3002. IMPROVEMENTS TO THE PHYSICIAN QUALITY REPORTING SYSTEM.

(a) EXTENSION.—Section 1848(m) of the Social Security Act (42 U.S.C. 1395w–4(m)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (A), in the matter preceding clause (i), by striking ''2010'' and inserting ''2014''; and

(B) in subparagraph (B)—

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

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

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

''(iii) for 2011, 1.0 percent; and

''(iv) for 2012, 2013, and 2014, 0.5 percent.'';

(2) in paragraph (3)—

(A) in subparagraph (A), in the matter preceding clause (i), by inserting ''(or, for purposes of subsection (a)(8), for the quality reporting period for the year)'' after ''reporting period''; and

(B) in subparagraph (C)(i), by inserting ", or, for purposes of subsection (a)(8), for a quality reporting period for the year" after "(a)(5), for a reporting period for a year";

(3) in paragraph (5)(E)(iv), by striking "subsection (a)(5)(A)" and inserting "paragraphs (5)(A) and (8)(A) of subsection (a)"; and

(4) in paragraph (6)(C)—

(A) in clause (i)(II), by striking ", 2009, 2010, and 2011" and inserting "and subsequent years"; and

(B) in clause (iii)—

(i) by inserting "(a)(8)" after "(a)(5)"; and

(ii) by striking "under subparagraph (D)(iii) of such subsection" and inserting "under subsection (a)(5)(D)(iii) or the quality reporting period under subsection (a)(8)(D)(iii), respectively".

(b) INCENTIVE PAYMENT ADJUSTMENT FOR QUALITY REPORTING.—Section 1848(a) of the Social Security Act (42 U.S.C. 1395w–4(a)) is amended by adding at the end the following new paragraph:

"(8) INCENTIVES FOR QUALITY REPORTING.—

"(A) ADJUSTMENT.—

1 "(i) IN GENERAL.—With respect to
2 covered professional services furnished by
3 an eligible professional during 2015 or any
4 subsequent year, if the eligible professional
5 does not satisfactorily submit data on qual-
6 ity measures for covered professional serv-
7 ices for the quality reporting period for the
8 year (as determined under subsection
9 (m)(3)(A)), the fee schedule amount for
10 such services furnished by such profes-
11 sional during the year (including the fee
12 schedule amount for purposes of deter-
13 mining a payment based on such amount)
14 shall be equal to the applicable percent of
15 the fee schedule amount that would other-
16 wise apply to such services under this sub-
17 section (determined after application of
18 paragraphs (3), (5), and (7), but without
19 regard to this paragraph).
20 "(ii) APPLICABLE PERCENT.—For
21 purposes of clause (i), the term 'applicable
22 percent' means—
23 "(I) for 2015, 98.5 percent; and
24 "(II) for 2016 and each subse-
25 quent year, 98 percent.

1 "(B) APPLICATION.—

2 "(i) PHYSICIAN REPORTING SYSTEM
3 RULES.—Paragraphs (5), (6), and (8) of
4 subsection (k) shall apply for purposes of
5 this paragraph in the same manner as they
6 apply for purposes of such subsection.

7 "(ii) INCENTIVE PAYMENT VALIDA-
8 TION RULES.—Clauses (ii) and (iii) of sub-
9 section (m)(5)(D) shall apply for purposes
10 of this paragraph in a similar manner as
11 they apply for purposes of such subsection.

12 "(C) DEFINITIONS.—For purposes of this
13 paragraph:

14 "(i) ELIGIBLE PROFESSIONAL; COV-
15 ERED PROFESSIONAL SERVICES.—The
16 terms 'eligible professional' and 'covered
17 professional services' have the meanings
18 given such terms in subsection (k)(3).

19 "(ii) PHYSICIAN REPORTING SYS-
20 TEM.—The term 'physician reporting sys-
21 tem' means the system established under
22 subsection (k).

23 "(iii) QUALITY REPORTING PERIOD.—
24 The term 'quality reporting period' means,

with respect to a year, a period specified by the Secretary.''.

(c) MAINTENANCE OF CERTIFICATION PROGRAMS.—

(1) IN GENERAL.—Section 1848(k)(4) of the Social Security Act (42 U.S.C. 1395w–4(k)(4)) is amended by inserting ''or through a Maintenance of Certification program operated by a specialty body of the American Board of Medical Specialties that meets the criteria for such a registry'' after ''Database)''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply for years after 2010.

(d) INTEGRATION OF PHYSICIAN QUALITY REPORTING AND EHR REPORTING.—Section 1848(m) of the Social Security Act (42 U.S.C. 1395w–4(m)) is amended by adding at the end the following new paragraph:

''(7) INTEGRATION OF PHYSICIAN QUALITY REPORTING AND EHR REPORTING.—Not later than January 1, 2012, the Secretary shall develop a plan to integrate reporting on quality measures under this subsection with reporting requirements under subsection (o) relating to the meaningful use of electronic health records. Such integration shall consist of the following:

"(A) The selection of measures, the reporting of which would both demonstrate—

"(i) meaningful use of an electronic health record for purposes of subsection (o); and

"(ii) quality of care furnished to an individual.

"(B) Such other activities as specified by the Secretary.".

(e) FEEDBACK.—Section 1848(m)(5) of the Social Security Act (42 U.S.C. 1395w–4(m)(5)) is amended by adding at the end the following new subparagraph:

"(H) FEEDBACK.—The Secretary shall provide timely feedback to eligible professionals on the performance of the eligible professional with respect to satisfactorily submitting data on quality measures under this subsection.".

(f) APPEALS.—Such section is further amended—

(1) in subparagraph (E), by striking "There shall" and inserting "Except as provided in subparagraph (I), there shall"; and

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

"(I) INFORMAL APPEALS PROCESS.—The Secretary shall, by not later than January 1,

2011, establish and have in place an informal process for eligible professionals to seek a review of the determination that an eligible professional did not satisfactorily submit data on quality measures under this subsection.''.

SEC. 3003. IMPROVEMENTS TO THE PHYSICIAN FEEDBACK PROGRAM.

(a) IN GENERAL.—Section 1848(n) of the Social Security Act (42 U.S.C. 1395w–4(n)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (A)—

(i) by striking ''GENERAL.—The Secretary'' and inserting ''GENERAL.—

''(i) ESTABLISHMENT.—The Secretary'';

(ii) in clause (i), as added by clause (i), by striking ''the 'Program')'' and all that follows through the period at the end of the second sentence and inserting ''the 'Program').''; and

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

''(ii) REPORTS ON RESOURCES.—The Secretary shall use claims data under this title (and may use other data) to provide

confidential reports to physicians (and, as determined appropriate by the Secretary, to groups of physicians) that measure the resources involved in furnishing care to individuals under this title.

"(iii) INCLUSION OF CERTAIN INFORMATION.—If determined appropriate by the Secretary, the Secretary may include information on the quality of care furnished to individuals under this title by the physician (or group of physicians) in such reports."; and

(B) in subparagraph (B), by striking "subparagraph (A)" and inserting "subparagraph (A)(ii)";

(2) in paragraph (4)—

(A) in the heading, by inserting "INITIAL" after "FOCUS"; and

(B) in the matter preceding subparagraph (A), by inserting "initial" after "focus the";

(3) in paragraph (6), by adding at the end the following new sentence: "For adjustments for reports on utilization under paragraph (9), see subparagraph (D) of such paragraph."; and

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

"(9) REPORTS ON UTILIZATION.—

"(A) DEVELOPMENT OF EPISODE GROUPER.—

"(i) IN GENERAL.—The Secretary shall develop an episode grouper that combines separate but clinically related items and services into an episode of care for an individual, as appropriate.

"(ii) TIMELINE FOR DEVELOPMENT.—The episode grouper described in subparagraph (A) shall be developed by not later than January 1, 2012.

"(iii) PUBLIC AVAILABILITY.—The Secretary shall make the details of the episode grouper described in subparagraph (A) available to the public.

"(iv) ENDORSEMENT.—The Secretary shall seek endorsement of the episode grouper described in subparagraph (A) by the entity with a contract under section 1890(a).

"(B) REPORTS ON UTILIZATION.—Effective beginning with 2012, the Secretary shall

1 provide reports to physicians that compare, as
2 determined appropriate by the Secretary, pat-
3 terns of resource use of the individual physician
4 to such patterns of other physicians.

5 "(C) ANALYSIS OF DATA.—The Secretary
6 shall, for purposes of preparing reports under
7 this paragraph, establish methodologies as ap-
8 propriate, such as to—

9 "(i) attribute episodes of care, in
10 whole or in part, to physicians;

11 "(ii) identify appropriate physicians
12 for purposes of comparison under subpara-
13 graph (B); and

14 "(iii) aggregate episodes of care at-
15 tributed to a physician under clause (i)
16 into a composite measure per individual.

17 "(D) DATA ADJUSTMENT.—In preparing
18 reports under this paragraph, the Secretary
19 shall make appropriate adjustments, including
20 adjustments—

21 "(i) to account for differences in so-
22 cioeconomic and demographic characteris-
23 tics, ethnicity, and health status of individ-
24 uals (such as to recognize that less healthy

individuals may require more intensive interventions); and

"(ii) to eliminate the effect of geographic adjustments in payment rates (as described in subsection (e)).

"(E) PUBLIC AVAILABILITY OF METHODOLOGY.—The Secretary shall make available to the public—

"(i) the methodologies established under subparagraph (C);

"(ii) information regarding any adjustments made to data under subparagraph (D); and

"(iii) aggregate reports with respect to physicians.

"(F) DEFINITION OF PHYSICIAN.—In this paragraph:

"(i) IN GENERAL.—The term 'physician' has the meaning given that term in section 1861(r)(1).

"(ii) TREATMENT OF GROUPS.—Such term includes, as the Secretary determines appropriate, a group of physicians.

"(G) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review

under section 1869, section 1878, or otherwise of the establishment of the methodology under subparagraph (C), including the determination of an episode of care under such methodology.

"(10) COORDINATION WITH OTHER VALUE-BASED PURCHASING REFORMS.—The Secretary shall coordinate the Program with the value-based payment modifier established under subsection (p) and, as the Secretary determines appropriate, other similar provisions of this title.".

(b) CONFORMING AMENDMENT.—Section 1890(b) of the Social Security Act (42 U.S.C. 1395aaa(b)) is amended by adding at the end the following new paragraph:

"(6) REVIEW AND ENDORSEMENT OF EPISODE GROUPER UNDER THE PHYSICIAN FEEDBACK PROGRAM.—The entity shall provide for the review and, as appropriate, the endorsement of the episode grouper developed by the Secretary under section 1848(n)(9)(A). Such review shall be conducted on an expedited basis.".

SEC. 3004. QUALITY REPORTING FOR LONG-TERM CARE HOSPITALS, INPATIENT REHABILITATION HOSPITALS, AND HOSPICE PROGRAMS.

(a) LONG-TERM CARE HOSPITALS.—Section 1886(m) of the Social Security Act (42 U.S.C.

1395ww(m)), as amended by section 3401(c), is amended by adding at the end the following new paragraph:

"(5) QUALITY REPORTING.—

"(A) REDUCTION IN UPDATE FOR FAILURE TO REPORT.—

"(i) IN GENERAL.—Under the system described in paragraph (1), for rate year 2014 and each subsequent rate year, in the case of a long-term care hospital that does not submit data to the Secretary in accordance with subparagraph (C) with respect to such a rate year, any annual update to a standard Federal rate for discharges for the hospital during the rate year, and after application of paragraph (3), shall be reduced by 2 percentage points.

"(ii) SPECIAL RULE.—The application of this subparagraph may result in such annual update being less than 0.0 for a rate year, and may result in payment rates under the system described in paragraph (1) for a rate year being less than such payment rates for the preceding rate year.

"(B) NONCUMULATIVE APPLICATION.—Any reduction under subparagraph (A) shall

1 apply only with respect to the rate year involved
2 and the Secretary shall not take into account
3 such reduction in computing the payment
4 amount under the system described in para-
5 graph (1) for a subsequent rate year.

6 "(C) SUBMISSION OF QUALITY DATA.—For
7 rate year 2014 and each subsequent rate year,
8 each long-term care hospital shall submit to the
9 Secretary data on quality measures specified
10 under subparagraph (D). Such data shall be
11 submitted in a form and manner, and at a time,
12 specified by the Secretary for purposes of this
13 subparagraph.

14 "(D) QUALITY MEASURES.—

15 "(i) IN GENERAL.—Subject to clause
16 (ii), any measure specified by the Secretary
17 under this subparagraph must have been
18 endorsed by the entity with a contract
19 under section 1890(a).

20 "(ii) EXCEPTION.—In the case of a
21 specified area or medical topic determined
22 appropriate by the Secretary for which a
23 feasible and practical measure has not
24 been endorsed by the entity with a contract
25 under section 1890(a), the Secretary may

1 specify a measure that is not so endorsed
2 as long as due consideration is given to
3 measures that have been endorsed or
4 adopted by a consensus organization iden-
5 tified by the Secretary.

6 ''(iii) TIME FRAME.—Not later than
7 October 1, 2012, the Secretary shall pub-
8 lish the measures selected under this sub-
9 paragraph that will be applicable with re-
10 spect to rate year 2014.

11 ''(E) PUBLIC AVAILABILITY OF DATA SUB-
12 MITTED.—The Secretary shall establish proce-
13 dures for making data submitted under sub-
14 paragraph (C) available to the public. Such pro-
15 cedures shall ensure that a long-term care hos-
16 pital has the opportunity to review the data
17 that is to be made public with respect to the
18 hospital prior to such data being made public.
19 The Secretary shall report quality measures
20 that relate to services furnished in inpatient
21 settings in long-term care hospitals on the
22 Internet website of the Centers for Medicare &
23 Medicaid Services.''.

1 (b) INPATIENT REHABILITATION HOSPITALS.—Sec-
2 tion 1886(j) of the Social Security Act (42 U.S.C.
3 1395ww(j)) is amended—
4 (1) by redesignating paragraph (7) as para-
5 graph (8); and
6 (2) by inserting after paragraph (6) the fol-
7 lowing new paragraph:
8 ''(7) QUALITY REPORTING.—
9 ''(A) REDUCTION IN UPDATE FOR FAILURE
10 TO REPORT.—
11 ''(i) IN GENERAL.—For purposes of
12 fiscal year 2014 and each subsequent fiscal
13 year, in the case of a rehabilitation facility
14 that does not submit data to the Secretary
15 in accordance with subparagraph (C) with
16 respect to such a fiscal year, after deter-
17 mining the increase factor described in
18 paragraph (3)(C), and after application of
19 paragraph (3)(D), the Secretary shall re-
20 duce such increase factor for payments for
21 discharges occurring during such fiscal
22 year by 2 percentage points.
23 ''(ii) SPECIAL RULE.—The application
24 of this subparagraph may result in the in-
25 crease factor described in paragraph (3)(C)

being less than 0.0 for a fiscal year, and may result in payment rates under this subsection for a fiscal year being less than such payment rates for the preceding fiscal year.

"(B) NONCUMULATIVE APPLICATION.—Any reduction under subparagraph (A) shall apply only with respect to the fiscal year involved and the Secretary shall not take into account such reduction in computing the payment amount under this subsection for a subsequent fiscal year.

"(C) SUBMISSION OF QUALITY DATA.—For fiscal year 2014 and each subsequent rate year, each rehabilitation facility shall submit to the Secretary data on quality measures specified under subparagraph (D). Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

"(D) QUALITY MEASURES.—

"(i) IN GENERAL.—Subject to clause (ii), any measure specified by the Secretary under this subparagraph must have been

endorsed by the entity with a contract under section 1890(a).

"(ii) EXCEPTION.—In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

"(iii) TIME FRAME.—Not later than October 1, 2012, the Secretary shall publish the measures selected under this subparagraph that will be applicable with respect to fiscal year 2014.

"(E) PUBLIC AVAILABILITY OF DATA SUBMITTED.—The Secretary shall establish procedures for making data submitted under subparagraph (C) available to the public. Such procedures shall ensure that a rehabilitation facility has the opportunity to review the data that is to be made public with respect to the facility

prior to such data being made public. The Secretary shall report quality measures that relate to services furnished in inpatient settings in rehabilitation facilities on the Internet website of the Centers for Medicare & Medicaid Services.''.

(c) HOSPICE PROGRAMS.—Section 1814(i) of the Social Security Act (42 U.S.C. 1395f(i)) is amended—

(1) by redesignating paragraph (5) as paragraph (6); and

(2) by inserting after paragraph (4) the following new paragraph:

''(5) QUALITY REPORTING.—

''(A) REDUCTION IN UPDATE FOR FAILURE TO REPORT.—

''(i) IN GENERAL.—For purposes of fiscal year 2014 and each subsequent fiscal year, in the case of a hospice program that does not submit data to the Secretary in accordance with subparagraph (C) with respect to such a fiscal year, after determining the market basket percentage increase under paragraph (1)(C)(ii)(VII) or paragraph (1)(C)(iii), as applicable, and after application of paragraph (1)(C)(iv), with respect to the fiscal year, the Sec-

1 retary shall reduce such market basket
2 percentage increase by 2 percentage points.
3 "(ii) SPECIAL RULE.—The application
4 of this subparagraph may result in the
5 market basket percentage increase under
6 paragraph (1)(C)(ii)(VII) or paragraph
7 (1)(C)(iii), as applicable, being less than
8 0.0 for a fiscal year, and may result in
9 payment rates under this subsection for a
10 fiscal year being less than such payment
11 rates for the preceding fiscal year.
12 "(B) NONCUMULATIVE APPLICATION.—
13 Any reduction under subparagraph (A) shall
14 apply only with respect to the fiscal year in-
15 volved and the Secretary shall not take into ac-
16 count such reduction in computing the payment
17 amount under this subsection for a subsequent
18 fiscal year.
19 "(C) SUBMISSION OF QUALITY DATA.—For
20 fiscal year 2014 and each subsequent fiscal
21 year, each hospice program shall submit to the
22 Secretary data on quality measures specified
23 under subparagraph (D). Such data shall be
24 submitted in a form and manner, and at a time,

1 specified by the Secretary for purposes of this
2 subparagraph.
3 "(D) QUALITY MEASURES.—
4 "(i) IN GENERAL.—Subject to clause
5 (ii), any measure specified by the Secretary
6 under this subparagraph must have been
7 endorsed by the entity with a contract
8 under section 1890(a).
9 "(ii) EXCEPTION.—In the case of a
10 specified area or medical topic determined
11 appropriate by the Secretary for which a
12 feasible and practical measure has not
13 been endorsed by the entity with a contract
14 under section 1890(a), the Secretary may
15 specify a measure that is not so endorsed
16 as long as due consideration is given to
17 measures that have been endorsed or
18 adopted by a consensus organization iden-
19 tified by the Secretary.
20 "(iii) TIME FRAME.—Not later than
21 October 1, 2012, the Secretary shall pub-
22 lish the measures selected under this sub-
23 paragraph that will be applicable with re-
24 spect to fiscal year 2014.

"(E) PUBLIC AVAILABILITY OF DATA SUBMITTED.—The Secretary shall establish procedures for making data submitted under subparagraph (C) available to the public. Such procedures shall ensure that a hospice program has the opportunity to review the data that is to be made public with respect to the hospice program prior to such data being made public. The Secretary shall report quality measures that relate to hospice care provided by hospice programs on the Internet website of the Centers for Medicare & Medicaid Services.".

SEC. 3005. QUALITY REPORTING FOR PPS-EXEMPT CANCER HOSPITALS.

Section 1866 of the Social Security Act (42 U.S.C. 1395cc) is amended—

(1) in subsection (a)(1)—

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

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

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

"(W) in the case of a hospital described in section 1886(d)(1)(B)(v), to report quality data

to the Secretary in accordance with subsection (k).''; and

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

''(k) QUALITY REPORTING BY CANCER HOSPITALS.—

''(1) IN GENERAL.—For purposes of fiscal year 2014 and each subsequent fiscal year, a hospital described in section 1886(d)(1)(B)(v) shall submit data to the Secretary in accordance with paragraph (2) with respect to such a fiscal year.

''(2) SUBMISSION OF QUALITY DATA.—For fiscal year 2014 and each subsequent fiscal year, each hospital described in such section shall submit to the Secretary data on quality measures specified under paragraph (3). Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

''(3) QUALITY MEASURES.—

''(A) IN GENERAL.—Subject to subparagraph (B), any measure specified by the Secretary under this paragraph must have been endorsed by the entity with a contract under section 1890(a).

1 "(B) EXCEPTION.—In the case of a speci-
2 fied area or medical topic determined appro-
3 priate by the Secretary for which a feasible and
4 practical measure has not been endorsed by the
5 entity with a contract under section 1890(a),
6 the Secretary may specify a measure that is not
7 so endorsed as long as due consideration is
8 given to measures that have been endorsed or
9 adopted by a consensus organization identified
10 by the Secretary.
11 "(C) TIME FRAME.—Not later than Octo-
12 ber 1, 2012, the Secretary shall publish the
13 measures selected under this paragraph that
14 will be applicable with respect to fiscal year
15 2014.
16 "(4) PUBLIC AVAILABILITY OF DATA SUB-
17 MITTED.—The Secretary shall establish procedures
18 for making data submitted under paragraph (4)
19 available to the public. Such procedures shall ensure
20 that a hospital described in section 1886(d)(1)(B)(v)
21 has the opportunity to review the data that is to be
22 made public with respect to the hospital prior to
23 such data being made public. The Secretary shall re-
24 port quality measures of process, structure, outcome,
25 patients' perspective on care, efficiency, and costs of

care that relate to services furnished in such hospitals on the Internet website of the Centers for Medicare & Medicaid Services.''.

SEC. 3006. PLANS FOR A VALUE-BASED PURCHASING PROGRAM FOR SKILLED NURSING FACILITIES AND HOME HEALTH AGENCIES.

(a) SKILLED NURSING FACILITIES.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall develop a plan to implement a value-based purchasing program for payments under the Medicare program under title XVIII of the Social Security Act for skilled nursing facilities (as defined in section 1819(a) of such Act (42 U.S.C. 1395i–3(a))).

(2) DETAILS.—In developing the plan under paragraph (1), the Secretary shall consider the following issues:

(A) The ongoing development, selection, and modification process for measures (including under section 1890 of the Social Security Act (42 U.S.C. 1395aaa) and section 1890A such Act, as added by section 3014), to the extent feasible and practicable, of all dimensions

of quality and efficiency in skilled nursing facilities.

(i) IN GENERAL.—Subject to clause (ii), any measure specified by the Secretary under subparagraph (A)(iii) must have been endorsed by the entity with a contract under section 1890(a).

(ii) EXCEPTION.—In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

(B) The reporting, collection, and validation of quality data.

(C) The structure of value-based payment adjustments, including the determination of thresholds or improvements in quality that would substantiate a payment adjustment, the

size of such payments, and the sources of funding for the value-based bonus payments.

(D) Methods for the public disclosure of information on the performance of skilled nursing facilities.

(E) Any other issues determined appropriate by the Secretary.

(3) CONSULTATION.—In developing the plan under paragraph (1), the Secretary shall—

(A) consult with relevant affected parties; and

(B) consider experience with such demonstrations that the Secretary determines are relevant to the value-based purchasing program described in paragraph (1).

(4) REPORT TO CONGRESS.—Not later than October 1, 2011, the Secretary shall submit to Congress a report containing the plan developed under paragraph (1).

(b) HOME HEALTH AGENCIES.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall develop a plan to implement a value-based purchasing program for payments under the Medicare program under title XVIII of the So-

cial Security Act for home health agencies (as defined in section 1861(o) of such Act (42 U.S.C. 1395x(o))).

(2) DETAILS.—In developing the plan under paragraph (1), the Secretary shall consider the following issues:

(A) The ongoing development, selection, and modification process for measures (including under section 1890 of the Social Security Act (42 U.S.C. 1395aaa) and section 1890A such Act, as added by section 3014), to the extent feasible and practicable, of all dimensions of quality and efficiency in home health agencies.

(B) The reporting, collection, and validation of quality data.

(C) The structure of value-based payment adjustments, including the determination of thresholds or improvements in quality that would substantiate a payment adjustment, the size of such payments, and the sources of funding for the value-based bonus payments.

(D) Methods for the public disclosure of information on the performance of home health agencies.

(E) Any other issues determined appropriate by the Secretary.

(3) CONSULTATION.—In developing the plan under paragraph (1), the Secretary shall—

(A) consult with relevant affected parties; and

(B) consider experience with such demonstrations that the Secretary determines are relevant to the value-based purchasing program described in paragraph (1).

(4) REPORT TO CONGRESS.—Not later than October 1, 2011, the Secretary shall submit to Congress a report containing the plan developed under paragraph (1).

SEC. 3007. VALUE-BASED PAYMENT MODIFIER UNDER THE PHYSICIAN FEE SCHEDULE.

Section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended—

(1) in subsection (b)(1), by inserting ''subject to subsection (p),'' after ''1998,''; and

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

''(p) ESTABLISHMENT OF VALUE-BASED PAYMENT MODIFIER.—

1 "(1) IN GENERAL.—The Secretary shall estab-
2 lish a payment modifier that provides for differential
3 payment to a physician or a group of physicians
4 under the fee schedule established under subsection
5 (b) based upon the quality of care furnished com-
6 pared to cost (as determined under paragraphs (2)
7 and (3), respectively) during a performance period.
8 Such payment modifier shall be separate from the
9 geographic adjustment factors established under
10 subsection (e).
11 "(2) QUALITY.—
12 "(A) IN GENERAL.—For purposes of para-
13 graph (1), quality of care shall be evaluated, to
14 the extent practicable, based on a composite of
15 measures of the quality of care furnished (as
16 established by the Secretary under subpara-
17 graph (B)).
18 "(B) MEASURES.—
19 "(i) The Secretary shall establish ap-
20 propriate measures of the quality of care
21 furnished by a physician or group of physi-
22 cians to individuals enrolled under this
23 part, such as measures that reflect health
24 outcomes. Such measures shall be risk ad-

1 justed as determined appropriate by the
2 Secretary.
3 "(ii) The Secretary shall seek endorse-
4 ment of the measures established under
5 this subparagraph by the entity with a
6 contract under section 1890(a).
7 "(3) COSTS.—For purposes of paragraph (1),
8 costs shall be evaluated, to the extent practicable,
9 based on a composite of appropriate measures of
10 costs established by the Secretary (such as the com-
11 posite measure under the methodology established
12 under subsection (n)(9)(C)(iii)) that eliminate the
13 effect of geographic adjustments in payment rates
14 (as described in subsection (e)), and take into ac-
15 count risk factors (such as socioeconomic and demo-
16 graphic characteristics, ethnicity, and health status
17 of individuals (such as to recognize that less healthy
18 individuals may require more intensive interventions)
19 and other factors determined appropriate by the
20 Secretary.
21 "(4) IMPLEMENTATION.—
22 "(A) PUBLICATION OF MEASURES, DATES
23 OF IMPLEMENTATION, PERFORMANCE PE-
24 RIOD.—Not later than January 1, 2012, the
25 Secretary shall publish the following:

"(i) The measures of quality of care and costs established under paragraphs (2) and (3), respectively.

"(ii) The dates for implementation of the payment modifier (as determined under subparagraph (B)).

"(iii) The initial performance period (as specified under subparagraph (B)(ii)).

"(B) DEADLINES FOR IMPLEMENTATION.—

"(i) INITIAL IMPLEMENTATION.—Subject to the preceding provisions of this subparagraph, the Secretary shall begin implementing the payment modifier established under this subsection through the rulemaking process during 2013 for the physician fee schedule established under subsection (b).

"(ii) INITIAL PERFORMANCE PERIOD.—

"(I) IN GENERAL.—The Secretary shall specify an initial performance period for application of the payment modifier established under this subsection with respect to 2015.

1 "(II) PROVISION OF INFORMA-
2 TION DURING INITIAL PERFORMANCE
3 PERIOD.—During the initial perform-
4 ance period, the Secretary shall, to
5 the extent practicable, provide infor-
6 mation to physicians and groups of
7 physicians about the quality of care
8 furnished by the physician or group of
9 physicians to individuals enrolled
10 under this part compared to cost (as
11 determined under paragraphs (2) and
12 (3), respectively) with respect to the
13 performance period.
14 "(iii) APPLICATION.—The Secretary
15 shall apply the payment modifier estab-
16 lished under this subsection for items and
17 services furnished—
18 "(I) beginning on January 1,
19 2015, with respect to specific physi-
20 cians and groups of physicians the
21 Secretary determines appropriate; and
22 "(II) beginning not later than
23 January 1, 2017, with respect to all
24 physicians and groups of physicians.

"(C) BUDGET NEUTRALITY.—The payment modifier established under this subsection shall be implemented in a budget neutral manner.

"(5) SYSTEMS-BASED CARE.—The Secretary shall, as appropriate, apply the payment modifier established under this subsection in a manner that promotes systems-based care.

"(6) CONSIDERATION OF SPECIAL CIRCUMSTANCES OF CERTAIN PROVIDERS.—In applying the payment modifier under this subsection, the Secretary shall, as appropriate, take into account the special circumstances of physicians or groups of physicians in rural areas and other underserved communities.

"(7) APPLICATION.—For purposes of the initial application of the payment modifier established under this subsection during the period beginning on January 1, 2015, and ending on December 31, 2016, the term 'physician' has the meaning given such term in section 1861(r). On or after January 1, 2017, the Secretary may apply this subsection to eligible professionals (as defined in subsection (k)(3)(B)) as the Secretary determines appropriate.

1 "(8) DEFINITIONS.—For purposes of this sub-
2 section:
3 "(A) COSTS.—The term 'costs' means ex-
4 penditures per individual as determined appro-
5 priate by the Secretary. In making the deter-
6 mination under the preceding sentence, the Sec-
7 retary may take into account the amount of
8 growth in expenditures per individual for a phy-
9 sician compared to the amount of such growth
10 for other physicians.
11 "(B) PERFORMANCE PERIOD.—The term
12 'performance period' means a period specified
13 by the Secretary.
14 "(9) COORDINATION WITH OTHER VALUE-
15 BASED PURCHASING REFORMS.—The Secretary shall
16 coordinate the value-based payment modifier estab-
17 lished under this subsection with the Physician
18 Feedback Program under subsection (n) and, as the
19 Secretary determines appropriate, other similar pro-
20 visions of this title.
21 "(10) LIMITATIONS ON REVIEW.—There shall
22 be no administrative or judicial review under section
23 1869, section 1878, or otherwise of—
24 "(A) the establishment of the value-based
25 payment modifier under this subsection;

"(B) the evaluation of quality of care under paragraph (2), including the establishment of appropriate measures of the quality of care under paragraph (2)(B);

"(C) the evaluation of costs under paragraph (3), including the establishment of appropriate measures of costs under such paragraph;

"(D) the dates for implementation of the value-based payment modifier;

"(E) the specification of the initial performance period and any other performance period under paragraphs (4)(B)(ii) and (8)(B), respectively;

"(F) the application of the value-based payment modifier under paragraph (7); and

"(G) the determination of costs under paragraph (8)(A).".

SEC. 3008. PAYMENT ADJUSTMENT FOR CONDITIONS ACQUIRED IN HOSPITALS.

(a) IN GENERAL.—Section 1886 of the Social Security Act (42 U.S.C. 1395ww), as amended by section 3001, is amended by adding at the end the following new subsection:

"(p) ADJUSTMENT TO HOSPITAL PAYMENTS FOR HOSPITAL ACQUIRED CONDITIONS.—

1 "(1) IN GENERAL.—In order to provide an in-
2 centive for applicable hospitals to reduce hospital ac-
3 quired conditions under this title, with respect to
4 discharges from an applicable hospital occurring
5 during fiscal year 2015 or a subsequent fiscal year,
6 the amount of payment under this section or section
7 1814(b)(3), as applicable, for such discharges during
8 the fiscal year shall be equal to 99 percent of the
9 amount of payment that would otherwise apply to
10 such discharges under this section or section
11 1814(b)(3) (determined after the application of sub-
12 sections (o) and (q) and section 1814(l)(4) but with-
13 out regard to this subsection).
14 "(2) APPLICABLE HOSPITALS.—
15 "(A) IN GENERAL.—For purposes of this
16 subsection, the term 'applicable hospital' means
17 a subsection (d) hospital that meets the criteria
18 described in subparagraph (B).
19 "(B) CRITERIA DESCRIBED.—
20 "(i) IN GENERAL.—The criteria de-
21 scribed in this subparagraph, with respect
22 to a subsection (d) hospital, is that the
23 subsection (d) hospital is in the top quar-
24 tile of all subsection (d) hospitals, relative
25 to the national average, of hospital ac-

1 quired conditions during the applicable pe-
2 riod, as determined by the Secretary.
3 "(ii) RISK ADJUSTMENT.—In carrying
4 out clause (i), the Secretary shall establish
5 and apply an appropriate risk adjustment
6 methodology.
7 "(C) EXEMPTION.—In the case of a hos-
8 pital that is paid under section 1814(b)(3), the
9 Secretary may exempt such hospital from the
10 application of this subsection if the State which
11 is paid under such section submits an annual
12 report to the Secretary describing how a similar
13 program in the State for a participating hos-
14 pital or hospitals achieves or surpasses the
15 measured results in terms of patient health out-
16 comes and cost savings established under this
17 subsection.
18 "(3) HOSPITAL ACQUIRED CONDITIONS.—For
19 purposes of this subsection, the term 'hospital ac-
20 quired condition' means a condition identified for
21 purposes of subsection (d)(4)(D)(iv) and any other
22 condition determined appropriate by the Secretary
23 that an individual acquires during a stay in an ap-
24 plicable hospital, as determined by the Secretary.

1 "(4) APPLICABLE PERIOD.—In this subsection,
2 the term 'applicable period' means, with respect to
3 a fiscal year, a period specified by the Secretary.
4 "(5) REPORTING TO HOSPITALS.—Prior to fis-
5 cal year 2015 and each subsequent fiscal year, the
6 Secretary shall provide confidential reports to appli-
7 cable hospitals with respect to hospital acquired con-
8 ditions of the applicable hospital during the applica-
9 ble period.
10 "(6) REPORTING HOSPITAL SPECIFIC INFORMA-
11 TION.—
12 "(A) IN GENERAL.—The Secretary shall
13 make information available to the public re-
14 garding hospital acquired conditions of each ap-
15 plicable hospital.
16 "(B) OPPORTUNITY TO REVIEW AND SUB-
17 MIT CORRECTIONS.—The Secretary shall ensure
18 that an applicable hospital has the opportunity
19 to review, and submit corrections for, the infor-
20 mation to be made public with respect to the
21 hospital under subparagraph (A) prior to such
22 information being made public.
23 "(C) WEBSITE.—Such information shall be
24 posted on the Hospital Compare Internet
25 website in an easily understandable format.

1 "(7) LIMITATIONS ON REVIEW.—There shall be
2 no administrative or judicial review under section
3 1869, section 1878, or otherwise of the following:
4 "(A) The criteria described in paragraph
5 (2)(A).
6 "(B) The specification of hospital acquired
7 conditions under paragraph (3).
8 "(C) The specification of the applicable pe-
9 riod under paragraph (4).
10 "(D) The provision of reports to applicable
11 hospitals under paragraph (5) and the informa-
12 tion made available to the public under para-
13 graph (6).".
14 (b) STUDY AND REPORT ON EXPANSION OF
15 HEALTHCARE ACQUIRED CONDITIONS POLICY TO OTHER
16 PROVIDERS.—
17 (1) STUDY.—The Secretary of Health and
18 Human Services shall conduct a study on expanding
19 the healthcare acquired conditions policy under sub-
20 section (d)(4)(D) of section 1886 of the Social Secu-
21 rity Act (42 U.S.C. 1395ww) to payments made to
22 other facilities under the Medicare program under
23 title XVIII of the Social Security Act, including such
24 payments made to inpatient rehabilitation facilities,
25 long-term care hospitals (as described in sub-

1 section(d)(1)(B)(iv) of such section), hospital out-
2 patient departments, and other hospitals excluded
3 from the inpatient prospective payment system
4 under such section, skilled nursing facilities, ambula-
5 tory surgical centers, and health clinics. Such study
6 shall include an analysis of how such policies could
7 impact quality of patient care, patient safety, and
8 spending under the Medicare program.

9 (2) REPORT.—Not later than January 1, 2012,
10 the Secretary shall submit to Congress a report con-
11 taining the results of the study conducted under
12 paragraph (1), together with recommendations for
13 such legislation and administrative action as the
14 Secretary determines appropriate.

15 **PART II—NATIONAL STRATEGY TO IMPROVE**
16 **HEALTH CARE QUALITY**

17 **SEC. 3011. NATIONAL STRATEGY.**

18 Title III of the Public Health Service Act (42 U.S.C.
19 241 et seq.) is amended by adding at the end the fol-
20 lowing:

1 **"PART S—HEALTH CARE QUALITY PROGRAMS**

2 **"Subpart I—National Strategy for Quality**

3 **Improvement in Health Care**

4 **"SEC. 399HH. NATIONAL STRATEGY FOR QUALITY IM-**

5 **PROVEMENT IN HEALTH CARE.**

6 ''(a) ESTABLISHMENT OF NATIONAL STRATEGY AND

7 PRIORITIES.—

8 ''(1) NATIONAL STRATEGY.—The Secretary,

9 through a transparent collaborative process, shall es-

10 tablish a national strategy to improve the delivery of

11 health care services, patient health outcomes, and

12 population health.

13 ''(2) IDENTIFICATION OF PRIORITIES.—

14 ''(A) IN GENERAL.—The Secretary shall

15 identify national priorities for improvement in

16 developing the strategy under paragraph (1).

17 ''(B) REQUIREMENTS.—The Secretary

18 shall ensure that priorities identified under sub-

19 paragraph (A) will—

20 ''(i) have the greatest potential for im-

21 proving the health outcomes, efficiency,

22 and patient-centeredness of health care for

23 all populations, including children and vul-

24 nerable populations;

25 ''(ii) identify areas in the delivery of

26 health care services that have the potential

1 for rapid improvement in the quality and
2 efficiency of patient care;
3 ''(iii) address gaps in quality, effi-
4 ciency, comparative effectiveness informa-
5 tion, and health outcomes measures and
6 data aggregation techniques;
7 ''(iv) improve Federal payment policy
8 to emphasize quality and efficiency;
9 ''(v) enhance the use of health care
10 data to improve quality, efficiency, trans-
11 parency, and outcomes;
12 ''(vi) address the health care provided
13 to patients with high-cost chronic diseases;
14 ''(vii) improve research and dissemi-
15 nation of strategies and best practices to
16 improve patient safety and reduce medical
17 errors, preventable admissions and re-
18 admissions, and health care-associated in-
19 fections;
20 ''(viii) reduce health disparities across
21 health disparity populations (as defined in
22 section 485E) and geographic areas; and
23 ''(ix) address other areas as deter-
24 mined appropriate by the Secretary.

1 "(C) CONSIDERATIONS.—In identifying
2 priorities under subparagraph (A), the Sec-
3 retary shall take into consideration the rec-
4 ommendations submitted by the entity with a
5 contract under section 1890(a) of the Social Se-
6 curity Act and other stakeholders.
7 "(D) COORDINATION WITH STATE AGEN-
8 CIES.—The Secretary shall collaborate, coordi-
9 nate, and consult with State agencies respon-
10 sible for administering the Medicaid program
11 under title XIX of the Social Security Act and
12 the Children's Health Insurance Program under
13 title XXI of such Act with respect to developing
14 and disseminating strategies, goals, models, and
15 timetables that are consistent with the national
16 priorities identified under subparagraph (A).
17 "(b) STRATEGIC PLAN.—
18 "(1) IN GENERAL.—The national strategy shall
19 include a comprehensive strategic plan to achieve the
20 priorities described in subsection (a).
21 "(2) REQUIREMENTS.—The strategic plan shall
22 include provisions for addressing, at a minimum, the
23 following:
24 "(A) Coordination among agencies within
25 the Department, which shall include steps to

1 minimize duplication of efforts and utilization
2 of common quality measures, where available.
3 Such common quality measures shall be meas-
4 ures identified by the Secretary under section
5 1139A or 1139B of the Social Security Act or
6 endorsed under section 1890 of such Act.
7 "(B) Agency-specific strategic plans to
8 achieve national priorities.
9 "(C) Establishment of annual benchmarks
10 for each relevant agency to achieve national pri-
11 orities.
12 "(D) A process for regular reporting by
13 the agencies to the Secretary on the implemen-
14 tation of the strategic plan.
15 "(E) Strategies to align public and private
16 payers with regard to quality and patient safety
17 efforts.
18 "(F) Incorporating quality improvement
19 and measurement in the strategic plan for
20 health information technology required by the
21 American Recovery and Reinvestment Act of
22 2009 (Public Law 111–5).
23 "(c) PERIODIC UPDATE OF NATIONAL STRATEGY.—
24 The Secretary shall update the national strategy not less

than annually. Any such update shall include a review of short- and long-term goals.

"(d) SUBMISSION AND AVAILABILITY OF NATIONAL STRATEGY AND UPDATES.—

"(1) DEADLINE FOR INITIAL SUBMISSION OF NATIONAL STRATEGY.—Not later than January 1, 2011, the Secretary shall submit to the relevant committees of Congress the national strategy described in subsection (a).

"(2) UPDATES.—

"(A) IN GENERAL.—The Secretary shall submit to the relevant committees of Congress an annual update to the strategy described in paragraph (1).

"(B) INFORMATION SUBMITTED.—Each update submitted under subparagraph (A) shall include—

"(i) a review of the short- and long-term goals of the national strategy and any gaps in such strategy;

"(ii) an analysis of the progress, or lack of progress, in meeting such goals and any barriers to such progress;

"(iii) the information reported under section 1139A of the Social Security Act,

consistent with the reporting requirements of such section; and

"(iv) in the case of an update required to be submitted on or after January 1, 2014, the information reported under section 1139B(b)(4) of the Social Security Act, consistent with the reporting requirements of such section.

"(C) SATISFACTION OF OTHER REPORTING REQUIREMENTS.—Compliance with the requirements of clauses (iii) and (iv) of subparagraph (B) shall satisfy the reporting requirements under sections 1139A(a)(6) and 1139B(b)(4), respectively, of the Social Security Act.

"(e) HEALTH CARE QUALITY INTERNET WEBSITE.—Not later than January 1, 2011, the Secretary shall create an Internet website to make public information regarding—

"(1) the national priorities for health care quality improvement established under subsection (a)(2);

"(2) the agency-specific strategic plans for health care quality described in subsection (b)(2)(B); and

"(3) other information, as the Secretary determines to be appropriate.".

SEC. 3012. INTERAGENCY WORKING GROUP ON HEALTH CARE QUALITY.

(a) IN GENERAL.—The President shall convene a working group to be known as the Interagency Working Group on Health Care Quality (referred to in this section as the ''Working Group'').

(b) GOALS.—The goals of the Working Group shall be to achieve the following:

(1) Collaboration, cooperation, and consultation between Federal departments and agencies with respect to developing and disseminating strategies, goals, models, and timetables that are consistent with the national priorities identified under section 399HH(a)(2) of the Public Health Service Act (as added by section 3011).

(2) Avoidance of inefficient duplication of quality improvement efforts and resources, where practicable, and a streamlined process for quality reporting and compliance requirements.

(3) Assess alignment of quality efforts in the public sector with private sector initiatives.

(c) COMPOSITION.—

(1) IN GENERAL.—The Working Group shall be composed of senior level representatives of—

(A) the Department of Health and Human Services;

1 (B) the Centers for Medicare & Medicaid
2 Services;
3 (C) the National Institutes of Health;
4 (D) the Centers for Disease Control and
5 Prevention;
6 (E) the Food and Drug Administration;
7 (F) the Health Resources and Services Ad-
8 ministration;
9 (G) the Agency for Healthcare Research
10 and Quality;
11 (H) the Office of the National Coordinator
12 for Health Information Technology;
13 (I) the Substance Abuse and Mental
14 Health Services Administration;
15 (J) the Administration for Children and
16 Families;
17 (K) the Department of Commerce;
18 (L) the Office of Management and Budget;
19 (M) the United States Coast Guard;
20 (N) the Federal Bureau of Prisons;
21 (O) the National Highway Traffic Safety
22 Administration;
23 (P) the Federal Trade Commission;
24 (Q) the Social Security Administration;
25 (R) the Department of Labor;

(S) the United States Office of Personnel Management;

(T) the Department of Defense;

(U) the Department of Education;

(V) the Department of Veterans Affairs;

(W) the Veterans Health Administration; and

(X) any other Federal agencies and departments with activities relating to improving health care quality and safety, as determined by the President.

(2) CHAIR AND VICE-CHAIR.—

(A) CHAIR.—The Working Group shall be chaired by the Secretary of Health and Human Services.

(B) VICE CHAIR.—Members of the Working Group, other than the Secretary of Health and Human Services, shall serve as Vice Chair of the Group on a rotating basis, as determined by the Group.

(d) REPORT TO CONGRESS.—Not later than December 31, 2010, and annually thereafter, the Working Group shall submit to the relevant Committees of Congress, and make public on an Internet website, a report describing

1 the progress and recommendations of the Working Group
2 in meeting the goals described in subsection (b).

3 **SEC. 3013. QUALITY MEASURE DEVELOPMENT.**

4 (a) PUBLIC HEALTH SERVICE ACT.—Title IX of the
5 Public Health Service Act (42 U.S.C. 299 et seq.) is
6 amended—

7 (1) by redesignating part D as part E;

8 (2) by redesignating sections 931 through 938
9 as sections 941 through 948, respectively;

10 (3) in section 948(1), as so redesignated, by
11 striking ''931'' and inserting ''941''; and

12 (4) by inserting after section 926 the following:

13 **''PART D—HEALTH CARE QUALITY**
14 **IMPROVEMENT**

15 **''Subpart I—Quality Measure Development**

16 **''SEC. 931. QUALITY MEASURE DEVELOPMENT.**

17 ''(a) QUALITY MEASURE.—In this subpart, the term
18 'quality measure' means a standard for measuring the per-
19 formance and improvement of population health or of
20 health plans, providers of services, and other clinicians in
21 the delivery of health care services.

22 ''(b) IDENTIFICATION OF QUALITY MEASURES.—

23 ''(1) IDENTIFICATION.—The Secretary, in con-
24 sultation with the Director of the Agency for
25 Healthcare Research and Quality and the Adminis-

1 trator of the Centers for Medicare & Medicaid Serv-
2 ices, shall identify, not less often than triennially,
3 gaps where no quality measures exist and existing
4 quality measures that need improvement, updating,
5 or expansion, consistent with the national strategy
6 under section 399HH, to the extent available, for
7 use in Federal health programs. In identifying such
8 gaps and existing quality measures that need im-
9 provement, the Secretary shall take into consider-
10 ation—
11 "(A) the gaps identified by the entity with
12 a contract under section 1890(a) of the Social
13 Security Act and other stakeholders;
14 "(B) quality measures identified by the pe-
15 diatric quality measures program under section
16 1139A of the Social Security Act; and
17 "(C) quality measures identified through
18 the Medicaid Quality Measurement Program
19 under section 1139B of the Social Security Act.
20 "(2) PUBLICATION.—The Secretary shall make
21 available to the public on an Internet website a re-
22 port on any gaps identified under paragraph (1) and
23 the process used to make such identification.
24 "(c) GRANTS OR CONTRACTS FOR QUALITY MEAS-
25 URE DEVELOPMENT.—

1 "(1) IN GENERAL.—The Secretary shall award
2 grants, contracts, or intergovernmental agreements
3 to eligible entities for purposes of developing, im-
4 proving, updating, or expanding quality measures
5 identified under subsection (b).
6 "(2) PRIORITIZATION IN THE DEVELOPMENT
7 OF QUALITY MEASURES.—In awarding grants, con-
8 tracts, or agreements under this subsection, the Sec-
9 retary shall give priority to the development of qual-
10 ity measures that allow the assessment of—
11 "(A) health outcomes and functional status
12 of patients;
13 "(B) the management and coordination of
14 health care across episodes of care and care
15 transitions for patients across the continuum of
16 providers, health care settings, and health
17 plans;
18 "(C) the experience, quality, and use of in-
19 formation provided to and used by patients,
20 caregivers, and authorized representatives to in-
21 form decisionmaking about treatment options,
22 including the use of shared decisionmaking
23 tools and preference sensitive care (as defined
24 in section 936);

1 "(D) the meaningful use of health informa-
2 tion technology;
3 "(E) the safety, effectiveness, patient-
4 centeredness, appropriateness, and timeliness of
5 care;
6 "(F) the efficiency of care;
7 "(G) the equity of health services and
8 health disparities across health disparity popu-
9 lations (as defined in section 485E) and geo-
10 graphic areas;
11 "(H) patient experience and satisfaction;
12 "(I) the use of innovative strategies and
13 methodologies identified under section 933; and
14 "(J) other areas determined appropriate by
15 the Secretary.
16 "(3) ELIGIBLE ENTITIES.—To be eligible for a
17 grant or contract under this subsection, an entity
18 shall—
19 "(A) have demonstrated expertise and ca-
20 pacity in the development and evaluation of
21 quality measures;
22 "(B) have adopted procedures to include in
23 the quality measure development process—

1 "(i) the views of those providers or
2 payers whose performance will be assessed
3 by the measure; and
4 "(ii) the views of other parties who
5 also will use the quality measures (such as
6 patients, consumers, and health care pur-
7 chasers);
8 "(C) collaborate with the entity with a con-
9 tract under section 1890(a) of the Social Secu-
10 rity Act and other stakeholders, as practicable,
11 and the Secretary so that quality measures de-
12 veloped by the eligible entity will meet the re-
13 quirements to be considered for endorsement by
14 the entity with a contract under such section
15 1890(a);
16 "(D) have transparent policies regarding
17 governance and conflicts of interest; and
18 "(E) submit an application to the Sec-
19 retary at such time and in such manner, as the
20 Secretary may require.
21 "(4) USE OF FUNDS.—An entity that receives
22 a grant, contract, or agreement under this sub-
23 section shall use such award to develop quality
24 measures that meet the following requirements:

"(A) Such measures support measures required to be reported under the Social Security Act, where applicable, and in support of gaps and existing quality measures that need improvement, as described in subsection (b)(1)(A).

"(B) Such measures support measures developed under section 1139A of the Social Security Act and the Medicaid Quality Measurement Program under section 1139B of such Act, where applicable.

"(C) To the extent practicable, data on such quality measures is able to be collected using health information technologies.

"(D) Each quality measure is free of charge to users of such measure.

"(E) Each quality measure is publicly available on an Internet website.

"(d) OTHER ACTIVITIES BY THE SECRETARY.—The Secretary may use amounts available under this section to update and test, where applicable, quality measures endorsed by the entity with a contract under section 1890(a) of the Social Security Act or adopted by the Secretary.

"(e) COORDINATION OF GRANTS.—The Secretary shall ensure that grants or contracts awarded under this section are coordinated with grants and contracts awarded

1 under sections 1139A(5) and 1139B(4)(A) of the Social
2 Security Act.''.
3 (b) SOCIAL SECURITY ACT.—Section 1890A of the
4 Social Security Act, as added by section 3014(b), is
5 amended by adding at the end the following new sub-
6 section:
7 ''(e) DEVELOPMENT OF QUALITY MEASURES.—The
8 Administrator of the Center for Medicare & Medicaid
9 Services shall through contracts develop quality measures
10 (as determined appropriate by the Administrator) for use
11 under this Act. In developing such measures, the Adminis-
12 trator shall consult with the Director of the Agency for
13 Healthcare Research and Quality.''.
14 (c) FUNDING.—There are authorized to be appro-
15 priated to the Secretary of Health and Human Services
16 to carry out this section, $75,000,000 for each of fiscal
17 years 2010 through 2014. Of the amounts appropriated
18 under the preceding sentence in a fiscal year, not less than
19 50 percent of such amounts shall be used pursuant to sub-
20 section (e) of section 1890A of the Social Security Act,
21 as added by subsection (b), with respect to programs
22 under such Act. Amounts appropriated under this sub-
23 section for a fiscal year shall remain available until ex-
24 pended.

SEC. 3014. QUALITY MEASUREMENT.

(a) NEW DUTIES FOR CONSENSUS-BASED ENTITY.—

(1) MULTI-STAKEHOLDER GROUP INPUT.—Section 1890(b) of the Social Security Act (42 U.S.C. 1395aaa(b)), as amended by section 3003, is amended by adding at the end the following new paragraphs:

"(7) CONVENING MULTI-STAKEHOLDER GROUPS.—

"(A) IN GENERAL.—The entity shall convene multi-stakeholder groups to provide input on—

"(i) the selection of quality measures described in subparagraph (B), from among—

"(I) such measures that have been endorsed by the entity; and

"(II) such measures that have not been considered for endorsement by such entity but are used or proposed to be used by the Secretary for the collection or reporting of quality measures; and

"(ii) national priorities (as identified under section 399HH of the Public Health Service Act) for improvement in population

1 health and in the delivery of health care
2 services for consideration under the na-
3 tional strategy established under section
4 399HH of the Public Health Service Act.
5 "(B) QUALITY MEASURES.—
6 "(i) IN GENERAL.—Subject to clause
7 (ii), the quality measures described in this
8 subparagraph are quality measures—
9 "(I) for use pursuant to sections
10 1814(i)(5)(D), 1833(i)(7),
11 1833(t)(17), 1848(k)(2)(C),
12 1866(k)(3), 1881(h)(2)(A)(iii),
13 1886(b)(3)(B)(viii), 1886(j)(7)(D),
14 1886(m)(5)(D), 1886(o)(2), and
15 1895(b)(3)(B)(v);
16 "(II) for use in reporting per-
17 formance information to the public;
18 and
19 "(III) for use in health care pro-
20 grams other than for use under this
21 Act.
22 "(ii) EXCLUSION.—Data sets (such as
23 the outcome and assessment information
24 set for home health services and the min-
25 imum data set for skilled nursing facility

1 services) that are used for purposes of
2 classification systems used in establishing
3 payment rates under this title shall not be
4 quality measures described in this subpara-
5 graph.
6 ''(C) REQUIREMENT FOR TRANSPARENCY
7 IN PROCESS.—
8 ''(i) IN GENERAL.—In convening
9 multi-stakeholder groups under subpara-
10 graph (A) with respect to the selection of
11 quality measures, the entity shall provide
12 for an open and transparent process for
13 the activities conducted pursuant to such
14 convening.
15 ''(ii) SELECTION OF ORGANIZATIONS
16 PARTICIPATING IN MULTI-STAKEHOLDER
17 GROUPS.—The process described in clause
18 (i) shall ensure that the selection of rep-
19 resentatives comprising such groups pro-
20 vides for public nominations for, and the
21 opportunity for public comment on, such
22 selection.
23 ''(D) MULTI-STAKEHOLDER GROUP DE-
24 FINED.—In this paragraph, the term 'multi-
25 stakeholder group' means, with respect to a

quality measure, a voluntary collaborative of organizations representing a broad group of stakeholders interested in or affected by the use of such quality measure.

"(8) TRANSMISSION OF MULTI-STAKEHOLDER INPUT.—Not later than February 1 of each year (beginning with 2012), the entity shall transmit to the Secretary the input of multi-stakeholder groups provided under paragraph (7).".

(2) ANNUAL REPORT.—Section 1890(b)(5)(A) of the Social Security Act (42 U.S.C. 1395aaa(b)(5)(A)) is amended—

(A) in clause (ii), by striking "and" at the end;

(B) in clause (iii), by striking the period at the end and inserting a semicolon; and

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

"(iv) gaps in endorsed quality measures, which shall include measures that are within priority areas identified by the Secretary under the national strategy established under section 399HH of the Public Health Service Act, and where quality

1 measures are unavailable or inadequate to
2 identify or address such gaps;
3 "(v) areas in which evidence is insuffi-
4 cient to support endorsement of quality
5 measures in priority areas identified by the
6 Secretary under the national strategy es-
7 tablished under section 399HH of the
8 Public Health Service Act and where tar-
9 geted research may address such gaps; and
10 "(vi) the matters described in clauses
11 (i) and (ii) of paragraph (7)(A).".
12 (b) MULTI-STAKEHOLDER GROUP INPUT INTO SE-
13 LECTION OF QUALITY MEASURES.—Title XVIII of the So-
14 cial Security Act (42 U.S.C. 1395 et seq.) is amended by
15 inserting after section 1890 the following:
16 "QUALITY MEASUREMENT
17 "SEC. 1890A. (a) MULTI-STAKEHOLDER GROUP
18 INPUT INTO SELECTION OF QUALITY MEASURES.—The
19 Secretary shall establish a pre-rulemaking process under
20 which the following steps occur with respect to the selec-
21 tion of quality measures described in section
22 1890(b)(7)(B):
23 "(1) INPUT.—Pursuant to section 1890(b)(7),
24 the entity with a contract under section 1890 shall
25 convene multi-stakeholder groups to provide input to

1 the Secretary on the selection of quality measures
2 described in subparagraph (B) of such paragraph.
3 "(2) PUBLIC AVAILABILITY OF MEASURES CON-
4 SIDERED FOR SELECTION.—Not later than Decem-
5 ber 1 of each year (beginning with 2011), the Sec-
6 retary shall make available to the public a list of
7 quality measures described in section 1890(b)(7)(B)
8 that the Secretary is considering under this title.
9 "(3) TRANSMISSION OF MULTI-STAKEHOLDER
10 INPUT.—Pursuant to section 1890(b)(8), not later
11 than February 1 of each year (beginning with
12 2012), the entity shall transmit to the Secretary the
13 input of multi-stakeholder groups described in para-
14 graph (1).
15 "(4) CONSIDERATION OF MULTI-STAKEHOLDER
16 INPUT.—The Secretary shall take into consideration
17 the input from multi-stakeholder groups described in
18 paragraph (1) in selecting quality measures de-
19 scribed in section 1890(b)(7)(B) that have been en-
20 dorsed by the entity with a contract under section
21 1890 and measures that have not been endorsed by
22 such entity.
23 "(5) RATIONALE FOR USE OF QUALITY MEAS-
24 URES.—The Secretary shall publish in the Federal
25 Register the rationale for the use of any quality

1 measure described in section 1890(b)(7)(B) that has
2 not been endorsed by the entity with a contract
3 under section 1890.
4 "(6) ASSESSMENT OF IMPACT.—Not later than
5 March 1, 2012, and at least once every three years
6 thereafter, the Secretary shall—
7 "(A) conduct an assessment of the quality
8 impact of the use of endorsed measures de-
9 scribed in section 1890(b)(7)(B); and
10 "(B) make such assessment available to
11 the public.
12 "(b) PROCESS FOR DISSEMINATION OF MEASURES
13 USED BY THE SECRETARY.—
14 "(1) IN GENERAL.—The Secretary shall estab-
15 lish a process for disseminating quality measures
16 used by the Secretary. Such process shall include the
17 following:
18 "(A) The incorporation of such measures,
19 where applicable, in workforce programs, train-
20 ing curricula, and any other means of dissemi-
21 nation determined appropriate by the Secretary.
22 "(B) The dissemination of such quality
23 measures through the national strategy devel-
24 oped under section 399HH of the Public Health
25 Service Act.

1 "(2) EXISTING METHODS.—To the extent prac-
2 ticable, the Secretary shall utilize and expand exist-
3 ing dissemination methods in disseminating quality
4 measures under the process established under para-
5 graph (1).
6 "(c) REVIEW OF QUALITY MEASURES USED BY THE
7 SECRETARY.—
8 "(1) IN GENERAL.—The Secretary shall—
9 "(A) periodically (but in no case less often
10 than once every 3 years) review quality meas-
11 ures described in section 1890(b)(7)(B); and
12 "(B) with respect to each such measure,
13 determine whether to—
14 "(i) maintain the use of such meas-
15 ure; or
16 "(ii) phase out such measure.
17 "(2) CONSIDERATIONS.—In conducting the re-
18 view under paragraph (1), the Secretary shall take
19 steps to—
20 "(A) seek to avoid duplication of measures
21 used; and
22 "(B) take into consideration current inno-
23 vative methodologies and strategies for quality
24 improvement practices in the delivery of health
25 care services that represent best practices for

1 such quality improvement and measures en-
2 dorsed by the entity with a contract under sec-
3 tion 1890 since the previous review by the Sec-
4 retary.

5 "(d) RULE OF CONSTRUCTION.—Nothing in this sec-
6 tion shall preclude a State from using the quality meas-
7 ures identified under sections 1139A and 1139B.".

8 (c) FUNDING.—For purposes of carrying out the
9 amendments made by this section, the Secretary shall pro-
10 vide for the transfer, from the Federal Hospital Insurance
11 Trust Fund under section 1817 of the Social Security Act
12 (42 U.S.C. 1395i) and the Federal Supplementary Med-
13 ical Insurance Trust Fund under section 1841 of such Act
14 (42 U.S.C. 1395t), in such proportion as the Secretary
15 determines appropriate, of $20,000,000, to the Centers for
16 Medicare & Medicaid Services Program Management Ac-
17 count for each of fiscal years 2010 through 2014.
18 Amounts transferred under the preceding sentence shall
19 remain available until expended.

20 **SEC. 3015. DATA COLLECTION; PUBLIC REPORTING.**

21 Title III of the Public Health Service Act (42 U.S.C.
22 241 et seq.), as amended by section 3011, is further
23 amended by adding at the end the following:

"SEC. 399II. COLLECTION AND ANALYSIS OF DATA FOR QUALITY AND RESOURCE USE MEASURES.

"(a) IN GENERAL.—The Secretary shall collect and aggregate consistent data on quality and resource use measures from information systems used to support health care delivery to implement the public reporting of performance information, as described in section 399JJ, and may award grants or contracts for this purpose. The Secretary shall ensure that such collection, aggregation, and analysis systems span an increasingly broad range of patient populations, providers, and geographic areas over time.

"(b) GRANTS OR CONTRACTS FOR DATA COLLECTION.—

"(1) IN GENERAL.—The Secretary may award grants or contracts to eligible entities to support new, or improve existing, efforts to collect and aggregate quality and resource use measures described under subsection (c).

"(2) ELIGIBLE ENTITIES.—To be eligible for a grant or contract under this subsection, an entity shall—

"(A) be—

"(i) a multi-stakeholder entity that coordinates the development of methods and implementation plans for the consistent re-

1 porting of summary quality and cost infor-
2 mation;
3 "(ii) an entity capable of submitting
4 such summary data for a particular popu-
5 lation and providers, such as a disease reg-
6 istry, regional collaboration, health plan
7 collaboration, or other population-wide
8 source; or
9 "(iii) a Federal Indian Health Service
10 program or a health program operated by
11 an Indian tribe (as defined in section 4 of
12 the Indian Health Care Improvement Act);
13 "(B) promote the use of the systems that
14 provide data to improve and coordinate patient
15 care;
16 "(C) support the provision of timely, con-
17 sistent quality and resource use information to
18 health care providers, and other groups and or-
19 ganizations as appropriate, with an opportunity
20 for providers to correct inaccurate measures;
21 and
22 "(D) agree to report, as determined by the
23 Secretary, measures on quality and resource use
24 to the public in accordance with the public re-

1 porting process established under section
2 399JJ.

3 "(c) CONSISTENT DATA AGGREGATION.—The Sec-
4 retary may award grants or contracts under this section
5 only to entities that enable summary data that can be inte-
6 grated and compared across multiple sources. The Sec-
7 retary shall provide standards for the protection of the se-
8 curity and privacy of patient data.

9 "(d) MATCHING FUNDS.—The Secretary may not
10 award a grant or contract under this section to an entity
11 unless the entity agrees that it will make available (di-
12 rectly or through contributions from other public or pri-
13 vate entities) non-Federal contributions toward the activi-
14 ties to be carried out under the grant or contract in an
15 amount equal to $1 for each $5 of Federal funds provided
16 under the grant or contract. Such non-Federal matching
17 funds may be provided directly or through donations from
18 public or private entities and may be in cash or in-kind,
19 fairly evaluated, including plant, equipment, or services.

20 "(e) AUTHORIZATION OF APPROPRIATIONS.—To
21 carry out this section, there are authorized to be appro-
22 priated such sums as may be necessary for fiscal years
23 2010 through 2014.

1 **"SEC. 399JJ. PUBLIC REPORTING OF PERFORMANCE IN-**
2 **FORMATION.**

3 "(a) DEVELOPMENT OF PERFORMANCE
4 WEBSITES.—The Secretary shall make available to the
5 public, through standardized Internet websites, perform-
6 ance information summarizing data on quality measures.
7 Such information shall be tailored to respond to the dif-
8 fering needs of hospitals and other institutional health
9 care providers, physicians and other clinicians, patients,
10 consumers, researchers, policymakers, States, and other
11 stakeholders, as the Secretary may specify.

12 "(b) INFORMATION ON CONDITIONS.—The perform-
13 ance information made publicly available on an Internet
14 website, as described in subsection (a), shall include infor-
15 mation regarding clinical conditions to the extent such in-
16 formation is available, and the information shall, where
17 appropriate, be provider-specific and sufficiently
18 disaggregated and specific to meet the needs of patients
19 with different clinical conditions.

20 "(c) CONSULTATION.—

21 "(1) IN GENERAL.—In carrying out this sec-
22 tion, the Secretary shall consult with the entity with
23 a contract under section 1890(a) of the Social Secu-
24 rity Act, and other entities, as appropriate, to deter-
25 mine the type of information that is useful to stake-
26 holders and the format that best facilitates use of

1 the reports and of performance reporting Internet
2 websites.
3 "(2) CONSULTATION WITH STAKEHOLDERS.—
4 The entity with a contract under section 1890(a) of
5 the Social Security Act shall convene multi-stake-
6 holder groups, as described in such section, to review
7 the design and format of each Internet website made
8 available under subsection (a) and shall transmit to
9 the Secretary the views of such multi-stakeholder
10 groups with respect to each such design and format.
11 "(d) COORDINATION.—Where appropriate, the Sec-
12 retary shall coordinate the manner in which data are pre-
13 sented through Internet websites described in subsection
14 (a) and for public reporting of other quality measures by
15 the Secretary, including such quality measures under title
16 XVIII of the Social Security Act.
17 "(e) AUTHORIZATION OF APPROPRIATIONS.—To
18 carry out this section, there are authorized to be appro-
19 priated such sums as may be necessary for fiscal years
20 2010 through 2014.".

1 **PART III—ENCOURAGING DEVELOPMENT OF**
2 **NEW PATIENT CARE MODELS**

3 **SEC. 3021. ESTABLISHMENT OF CENTER FOR MEDICARE**
4 **AND MEDICAID INNOVATION WITHIN CMS.**

5 (a) IN GENERAL.—Title XI of the Social Security Act
6 is amended by inserting after section 1115 the following
7 new section:

8 ''CENTER FOR MEDICARE AND MEDICAID INNOVATION

9 ''SEC. 1115A. (a) CENTER FOR MEDICARE AND
10 MEDICAID INNOVATION ESTABLISHED.—

11 ''(1) IN GENERAL.—There is created within the
12 Centers for Medicare & Medicaid Services a Center
13 for Medicare and Medicaid Innovation (in this sec-
14 tion referred to as the 'CMI') to carry out the duties
15 described in this section. The purpose of the CMI is
16 to test innovative payment and service delivery mod-
17 els to reduce program expenditures under the appli-
18 cable titles while preserving or enhancing the quality
19 of care furnished to individuals under such titles. In
20 selecting such models, the Secretary shall give pref-
21 erence to models that also improve the coordination,
22 quality, and efficiency of health care services fur-
23 nished to applicable individuals defined in paragraph
24 (4)(A).

1 "(2) DEADLINE.—The Secretary shall ensure
2 that the CMI is carrying out the duties described in
3 this section by not later than January 1, 2011.
4 "(3) CONSULTATION.—In carrying out the du-
5 ties under this section, the CMI shall consult rep-
6 resentatives of relevant Federal agencies, and clin-
7 ical and analytical experts with expertise in medicine
8 and health care management. The CMI shall use
9 open door forums or other mechanisms to seek input
10 from interested parties.
11 "(4) DEFINITIONS.—In this section:
12 "(A) APPLICABLE INDIVIDUAL.—The term
13 'applicable individual' means—
14 "(i) an individual who is entitled to,
15 or enrolled for, benefits under part A of
16 title XVIII or enrolled for benefits under
17 part B of such title;
18 "(ii) an individual who is eligible for
19 medical assistance under title XIX, under
20 a State plan or waiver; or
21 "(iii) an individual who meets the cri-
22 teria of both clauses (i) and (ii).
23 "(B) APPLICABLE TITLE.—The term 'ap-
24 plicable title' means title XVIII, title XIX, or
25 both.

1 "(b) TESTING OF MODELS (PHASE I).—

2 "(1) IN GENERAL.—The CMI shall test pay-
3 ment and service delivery models in accordance with
4 selection criteria under paragraph (2) to determine
5 the effect of applying such models under the applica-
6 ble title (as defined in subsection (a)(4)(B)) on pro-
7 gram expenditures under such titles and the quality
8 of care received by individuals receiving benefits
9 under such title.

10 "(2) SELECTION OF MODELS TO BE TESTED.—

11 "(A) IN GENERAL.—The Secretary shall
12 select models to be tested from models where
13 the Secretary determines that there is evidence
14 that the model addresses a defined population
15 for which there are deficits in care leading to
16 poor clinical outcomes or potentially avoidable
17 expenditures. The models selected under the
18 preceding sentence may include the models de-
19 scribed in subparagraph (B).

20 "(B) OPPORTUNITIES.—The models de-
21 scribed in this subparagraph are the following
22 models:

23 "(i) Promoting broad payment and
24 practice reform in primary care, including
25 patient-centered medical home models for

high-need applicable individuals, medical homes that address women's unique health care needs, and models that transition primary care practices away from fee-for-service based reimbursement and toward comprehensive payment or salary-based payment.

''(ii) Contracting directly with groups of providers of services and suppliers to promote innovative care delivery models, such as through risk-based comprehensive payment or salary-based payment.

''(iii) Utilizing geriatric assessments and comprehensive care plans to coordinate the care (including through interdisciplinary teams) of applicable individuals with multiple chronic conditions and at least one of the following:

''(I) An inability to perform 2 or more activities of daily living.

''(II) Cognitive impairment, including dementia.

''(iv) Promote care coordination between providers of services and suppliers that transition health care providers away

1 from fee-for-service based reimbursement
2 and toward salary-based payment.
3 "(v) Supporting care coordination for
4 chronically-ill applicable individuals at high
5 risk of hospitalization through a health in-
6 formation technology-enabled provider net-
7 work that includes care coordinators, a
8 chronic disease registry, and home tele-
9 health technology.
10 "(vi) Varying payment to physicians
11 who order advanced diagnostic imaging
12 services (as defined in section
13 1834(e)(1)(B)) according to the physi-
14 cian's adherence to appropriateness criteria
15 for the ordering of such services, as deter-
16 mined in consultation with physician spe-
17 cialty groups and other relevant stake-
18 holders.
19 "(vii) Utilizing medication therapy
20 management services, such as those de-
21 scribed in section 935 of the Public Health
22 Service Act.
23 "(viii) Establishing community-based
24 health teams to support small-practice
25 medical homes by assisting the primary

1 care practitioner in chronic care manage-
2 ment, including patient self-management,
3 activities.

4 "(ix) Assisting applicable individuals
5 in making informed health care choices by
6 paying providers of services and suppliers
7 for using patient decision-support tools, in-
8 cluding tools that meet the standards de-
9 veloped and identified under section
10 936(c)(2)(A) of the Public Health Service
11 Act, that improve applicable individual and
12 caregiver understanding of medical treat-
13 ment options.

14 "(x) Allowing States to test and
15 evaluate fully integrating care for dual eli-
16 gible individuals in the State, including the
17 management and oversight of all funds
18 under the applicable titles with respect to
19 such individuals.

20 "(xi) Allowing States to test and
21 evaluate systems of all-payer payment re-
22 form for the medical care of residents of
23 the State, including dual eligible individ-
24 uals.

"(xii) Aligning nationally recognized, evidence-based guidelines of cancer care with payment incentives under title XVIII in the areas of treatment planning and follow-up care planning for applicable individuals described in clause (i) or (iii) of subsection (a)(4)(A) with cancer, including the identification of gaps in applicable quality measures.

"(xiii) Improving post-acute care through continuing care hospitals that offer inpatient rehabilitation, long-term care hospitals, and home health or skilled nursing care during an inpatient stay and the 30 days immediately following discharge.

"(xiv) Funding home health providers who offer chronic care management services to applicable individuals in cooperation with interdisciplinary teams.

"(xv) Promoting improved quality and reduced cost by developing a collaborative of high-quality, low-cost health care institutions that is responsible for—

1 "(I) developing, documenting,
2 and disseminating best practices and
3 proven care methods;
4 "(II) implementing such best
5 practices and proven care methods
6 within such institutions to dem-
7 onstrate further improvements in
8 quality and efficiency; and
9 "(III) providing assistance to
10 other health care institutions on how
11 best to employ such best practices and
12 proven care methods to improve
13 health care quality and lower costs.
14 "(xvi) Facilitate inpatient care, in-
15 cluding intensive care, of hospitalized ap-
16 plicable individuals at their local hospital
17 through the use of electronic monitoring by
18 specialists, including intensivists and crit-
19 ical care specialists, based at integrated
20 health systems.
21 "(xvii) Promoting greater efficiencies
22 and timely access to outpatient services
23 (such as outpatient physical therapy serv-
24 ices) through models that do not require a
25 physician or other health professional to

1 refer the service or be involved in estab-
2 lishing the plan of care for the service,
3 when such service is furnished by a health
4 professional who has the authority to fur-
5 nish the service under existing State law.
6 "(xviii) Establishing comprehensive
7 payments to Healthcare Innovation Zones,
8 consisting of groups of providers that in-
9 clude a teaching hospital, physicians, and
10 other clinical entities, that, through their
11 structure, operations, and joint-activity de-
12 liver a full spectrum of integrated and
13 comprehensive health care services to ap-
14 plicable individuals while also incorporating
15 innovative methods for the clinical training
16 of future health care professionals.
17 "(C) ADDITIONAL FACTORS FOR CONSID-
18 ERATION.—In selecting models for testing
19 under subparagraph (A), the CMI may consider
20 the following additional factors:
21 "(i) Whether the model includes a
22 regular process for monitoring and updat-
23 ing patient care plans in a manner that is
24 consistent with the needs and preferences
25 of applicable individuals.

"(ii) Whether the model places the applicable individual, including family members and other informal caregivers of the applicable individual, at the center of the care team of the applicable individual.

"(iii) Whether the model provides for in-person contact with applicable individuals.

"(iv) Whether the model utilizes technology, such as electronic health records and patient-based remote monitoring systems, to coordinate care over time and across settings.

"(v) Whether the model provides for the maintenance of a close relationship between care coordinators, primary care practitioners, specialist physicians, community-based organizations, and other providers of services and suppliers.

"(vi) Whether the model relies on a team-based approach to interventions, such as comprehensive care assessments, care planning, and self-management coaching.

"(vii) Whether, under the model, providers of services and suppliers are able to

share information with patients, caregivers, and other providers of services and suppliers on a real time basis.

"(3) BUDGET NEUTRALITY.—

"(A) INITIAL PERIOD.—The Secretary shall not require, as a condition for testing a model under paragraph (1), that the design of such model ensure that such model is budget neutral initially with respect to expenditures under the applicable title.

"(B) TERMINATION OR MODIFICATION.—The Secretary shall terminate or modify the design and implementation of a model unless the Secretary determines (and the Chief Actuary of the Centers for Medicare & Medicaid Services, with respect to program spending under the applicable title, certifies), after testing has begun, that the model is expected to—

"(i) improve the quality of care (as determined by the Administrator of the Centers for Medicare & Medicaid Services) without increasing spending under the applicable title;

"(ii) reduce spending under the applicable title without reducing the quality of care; or

"(iii) improve the quality of care and reduce spending.

Such termination may occur at any time after such testing has begun and before completion of the testing.

"(4) EVALUATION.—

"(A) IN GENERAL.—The Secretary shall conduct an evaluation of each model tested under this subsection. Such evaluation shall include an analysis of—

"(i) the quality of care furnished under the model, including the measurement of patient-level outcomes and patient-centeredness criteria determined appropriate by the Secretary; and

"(ii) the changes in spending under the applicable titles by reason of the model.

"(B) INFORMATION.—The Secretary shall make the results of each evaluation under this paragraph available to the public in a timely fashion and may establish requirements for

1 States and other entities participating in the
2 testing of models under this section to collect
3 and report information that the Secretary de-
4 termines is necessary to monitor and evaluate
5 such models.

6 "(c) EXPANSION OF MODELS (PHASE II).—Taking
7 into account the evaluation under subsection (b)(4), the
8 Secretary may, through rulemaking, expand (including im-
9 plementation on a nationwide basis) the duration and the
10 scope of a model that is being tested under subsection (b)
11 or a demonstration project under section 1866C, to the
12 extent determined appropriate by the Secretary, if—

13 "(1) the Secretary determines that such expan-
14 sion is expected to—

15 "(A) reduce spending under applicable title
16 without reducing the quality of care; or

17 "(B) improve the quality of care and re-
18 duce spending; and

19 "(2) the Chief Actuary of the Centers for Medi-
20 care & Medicaid Services certifies that such expan-
21 sion would reduce program spending under applica-
22 ble titles.

23 "(d) IMPLEMENTATION.—

24 "(1) WAIVER AUTHORITY.—The Secretary may
25 waive such requirements of titles XI and XVIII and

of sections 1902(a)(1), 1902(a)(13), and 1903(m)(2)(A)(iii) as may be necessary solely for purposes of carrying out this section with respect to testing models described in subsection (b).

"(2) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of—

"(A) the selection of models for testing or expansion under this section;

"(B) the selection of organizations, sites, or participants to test those models selected;

"(C) the elements, parameters, scope, and duration of such models for testing or dissemination;

"(D) determinations regarding budget neutrality under subsection (b)(3);

"(E) the termination or modification of the design and implementation of a model under subsection (b)(3)(B); and

"(F) determinations about expansion of the duration and scope of a model under subsection (c), including the determination that a model is not expected to meet criteria described in paragraph (1) or (2) of such subsection.

"(3) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to the testing and evaluation of models or expansion of such models under this section.

"(e) APPLICATION TO CHIP.—The Center may carry out activities under this section with respect to title XXI in the same manner as provided under this section with respect to the program under the applicable titles.

"(f) FUNDING.—

"(1) IN GENERAL.—There are appropriated, from amounts in the Treasury not otherwise appropriated—

"(A) $5,000,000 for the design, implementation, and evaluation of models under subsection (b) for fiscal year 2010;

"(B) $10,000,000,000 for the activities initiated under this section for the period of fiscal years 2011 through 2019; and

"(C) the amount described in subparagraph (B) for the activities initiated under this section for each subsequent 10-year fiscal period (beginning with the 10-year fiscal period beginning with fiscal year 2020).

Amounts appropriated under the preceding sentence shall remain available until expended.

"(2) USE OF CERTAIN FUNDS.—Out of amounts appropriated under subparagraphs (B) and (C) of paragraph (1), not less than $25,000,000 shall be made available each such fiscal year to design, implement, and evaluate models under subsection (b).

"(g) REPORT TO CONGRESS.—Beginning in 2012, and not less than once every other year thereafter, the Secretary shall submit to Congress a report on activities under this section. Each such report shall describe the models tested under subsection (b), including the number of individuals described in subsection (a)(4)(A)(i) and of individuals described in subsection (a)(4)(A)(ii) participating in such models and payments made under applicable titles for services on behalf of such individuals, any models chosen for expansion under subsection (c), and the results from evaluations under subsection (b)(4). In addition, each such report shall provide such recommendations as the Secretary determines are appropriate for legislative action to facilitate the development and expansion of successful payment models.".

(b) MEDICAID CONFORMING AMENDMENT.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by section 8002(b), is amended—

(1) in paragraph (81), by striking ''and'' at the end;

(2) in paragraph (82), by striking the period at the end and inserting ''; and''; and

(3) by inserting after paragraph (82) the following new paragraph:

''(83) provide for implementation of the payment models specified by the Secretary under section 1115A(c) for implementation on a nationwide basis unless the State demonstrates to the satisfaction of the Secretary that implementation would not be administratively feasible or appropriate to the health care delivery system of the State.''.

(c) REVISIONS TO HEALTH CARE QUALITY DEMONSTRATION PROGRAM.—Subsections (b) and (f) of section 1866C of the Social Security Act (42 U.S.C. 1395cc–3) are amended by striking ''5-year'' each place it appears.

SEC. 3022. MEDICARE SHARED SAVINGS PROGRAM.

Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by adding at the end the following new section:

''SHARED SAVINGS PROGRAM

''SEC. 1899. (a) ESTABLISHMENT.—

''(1) IN GENERAL.—Not later than January 1, 2012, the Secretary shall establish a shared savings program (in this section referred to as the 'pro-

1 gram') that promotes accountability for a patient
2 population and coordinates items and services under
3 parts A and B, and encourages investment in infra-
4 structure and redesigned care processes for high
5 quality and efficient service delivery. Under such
6 program—

7 "(A) groups of providers of services and
8 suppliers meeting criteria specified by the Sec-
9 retary may work together to manage and co-
10 ordinate care for Medicare fee-for-service bene-
11 ficiaries through an accountable care organiza-
12 tion (referred to in this section as an 'ACO');
13 and

14 "(B) ACOs that meet quality performance
15 standards established by the Secretary are eligi-
16 ble to receive payments for shared savings
17 under subsection (d)(2).

18 "(b) ELIGIBLE ACOS.—

19 "(1) IN GENERAL.—Subject to the succeeding
20 provisions of this subsection, as determined appro-
21 priate by the Secretary, the following groups of pro-
22 viders of services and suppliers which have estab-
23 lished a mechanism for shared governance are eligi-
24 ble to participate as ACOs under the program under
25 this section:

1 "(A) ACO professionals in group practice
2 arrangements.
3 "(B) Networks of individual practices of
4 ACO professionals.
5 "(C) Partnerships or joint venture ar-
6 rangements between hospitals and ACO profes-
7 sionals.
8 "(D) Hospitals employing ACO profes-
9 sionals.
10 "(E) Such other groups of providers of
11 services and suppliers as the Secretary deter-
12 mines appropriate.
13 "(2) REQUIREMENTS.—An ACO shall meet the
14 following requirements:
15 "(A) The ACO shall be willing to become
16 accountable for the quality, cost, and overall
17 care of the Medicare fee-for-service beneficiaries
18 assigned to it.
19 "(B) The ACO shall enter into an agree-
20 ment with the Secretary to participate in the
21 program for not less than a 3-year period (re-
22 ferred to in this section as the 'agreement pe-
23 riod').
24 "(C) The ACO shall have a formal legal
25 structure that would allow the organization to

1 receive and distribute payments for shared sav-
2 ings under subsection (d)(2) to participating
3 providers of services and suppliers.

4 "(D) The ACO shall include primary care
5 ACO professionals that are sufficient for the
6 number of Medicare fee-for-service beneficiaries
7 assigned to the ACO under subsection (c). At a
8 minimum, the ACO shall have at least 5,000
9 such beneficiaries assigned to it under sub-
10 section (c) in order to be eligible to participate
11 in the ACO program.

12 "(E) The ACO shall provide the Secretary
13 with such information regarding ACO profes-
14 sionals participating in the ACO as the Sec-
15 retary determines necessary to support the as-
16 signment of Medicare fee-for-service bene-
17 ficiaries to an ACO, the implementation of
18 quality and other reporting requirements under
19 paragraph (3), and the determination of pay-
20 ments for shared savings under subsection
21 (d)(2).

22 "(F) The ACO shall have in place a leader-
23 ship and management structure that includes
24 clinical and administrative systems.

1 "(G) The ACO shall define processes to
2 promote evidence-based medicine and patient
3 engagement, report on quality and cost meas-
4 ures, and coordinate care, such as through the
5 use of telehealth, remote patient monitoring,
6 and other such enabling technologies.
7 "(H) The ACO shall demonstrate to the
8 Secretary that it meets patient-centeredness cri-
9 teria specified by the Secretary, such as the use
10 of patient and caregiver assessments or the use
11 of individualized care plans.
12 "(3) QUALITY AND OTHER REPORTING RE-
13 QUIREMENTS.—
14 "(A) IN GENERAL.—The Secretary shall
15 determine appropriate measures to assess the
16 quality of care furnished by the ACO, such as
17 measures of—
18 "(i) clinical processes and outcomes;
19 "(ii) patient and, where practicable,
20 caregiver experience of care; and
21 "(iii) utilization (such as rates of hos-
22 pital admissions for ambulatory care sen-
23 sitive conditions).
24 "(B) REPORTING REQUIREMENTS.—An
25 ACO shall submit data in a form and manner

1 specified by the Secretary on measures the Sec-
2 retary determines necessary for the ACO to re-
3 port in order to evaluate the quality of care fur-
4 nished by the ACO. Such data may include care
5 transitions across health care settings, including
6 hospital discharge planning and post-hospital
7 discharge follow-up by ACO professionals, as
8 the Secretary determines appropriate.

9 "(C) QUALITY PERFORMANCE STAND-
10 ARDS.—The Secretary shall establish quality
11 performance standards to assess the quality of
12 care furnished by ACOs. The Secretary shall
13 seek to improve the quality of care furnished by
14 ACOs over time by specifying higher standards,
15 new measures, or both for purposes of assessing
16 such quality of care.

17 "(D) OTHER REPORTING REQUIRE-
18 MENTS.—The Secretary may, as the Secretary
19 determines appropriate, incorporate reporting
20 requirements and incentive payments related to
21 the physician quality reporting initiative
22 (PQRI) under section 1848, including such re-
23 quirements and such payments related to elec-
24 tronic prescribing, electronic health records,
25 and other similar initiatives under section 1848,

and may use alternative criteria than would otherwise apply under such section for determining whether to make such payments. The incentive payments described in the preceding sentence shall not be taken into consideration when calculating any payments otherwise made under subsection (d).

"(4) NO DUPLICATION IN PARTICIPATION IN SHARED SAVINGS PROGRAMS.—A provider of services or supplier that participates in any of the following shall not be eligible to participate in an ACO under this section:

"(A) A model tested or expanded under section 1115A that involves shared savings under this title, or any other program or demonstration project that involves such shared savings.

"(B) The independence at home medical practice pilot program under section 1866E.

"(c) ASSIGNMENT OF MEDICARE FEE-FOR-SERVICE BENEFICIARIES TO ACOS.—The Secretary shall determine an appropriate method to assign Medicare fee-for-service beneficiaries to an ACO based on their utilization of primary care services provided under this title by an ACO professional described in subsection (h)(1)(A).

1 "(d) PAYMENTS AND TREATMENT OF SAVINGS.—
2 "(1) PAYMENTS.—
3 "(A) IN GENERAL.—Under the program,
4 subject to paragraph (3), payments shall con-
5 tinue to be made to providers of services and
6 suppliers participating in an ACO under the
7 original Medicare fee-for-service program under
8 parts A and B in the same manner as they
9 would otherwise be made except that a partici-
10 pating ACO is eligible to receive payment for
11 shared savings under paragraph (2) if—
12 "(i) the ACO meets quality perform-
13 ance standards established by the Sec-
14 retary under subsection (b)(3); and
15 "(ii) the ACO meets the requirement
16 under subparagraph (B)(i).
17 "(B) SAVINGS REQUIREMENT AND BENCH-
18 MARK.—
19 "(i) DETERMINING SAVINGS.—In each
20 year of the agreement period, an ACO
21 shall be eligible to receive payment for
22 shared savings under paragraph (2) only if
23 the estimated average per capita Medicare
24 expenditures under the ACO for Medicare
25 fee-for-service beneficiaries for parts A and

1 B services, adjusted for beneficiary charac-
2 teristics, is at least the percent specified by
3 the Secretary below the applicable bench-
4 mark under clause (ii). The Secretary shall
5 determine the appropriate percent de-
6 scribed in the preceding sentence to ac-
7 count for normal variation in expenditures
8 under this title, based upon the number of
9 Medicare fee-for-service beneficiaries as-
10 signed to an ACO.
11 ''(ii) ESTABLISH AND UPDATE
12 BENCHMARK.—The Secretary shall esti-
13 mate a benchmark for each agreement pe-
14 riod for each ACO using the most recent
15 available 3 years of per-beneficiary expend-
16 itures for parts A and B services for Medi-
17 care fee-for-service beneficiaries assigned
18 to the ACO. Such benchmark shall be ad-
19 justed for beneficiary characteristics and
20 such other factors as the Secretary deter-
21 mines appropriate and updated by the pro-
22 jected absolute amount of growth in na-
23 tional per capita expenditures for parts A
24 and B services under the original Medicare
25 fee-for-service program, as estimated by

the Secretary. Such benchmark shall be reset at the start of each agreement period.

"(2) PAYMENTS FOR SHARED SAVINGS.—Subject to performance with respect to the quality performance standards established by the Secretary under subsection (b)(3), if an ACO meets the requirements under paragraph (1), a percent (as determined appropriate by the Secretary) of the difference between such estimated average per capita Medicare expenditures in a year, adjusted for beneficiary characteristics, under the ACO and such benchmark for the ACO may be paid to the ACO as shared savings and the remainder of such difference shall be retained by the program under this title. The Secretary shall establish limits on the total amount of shared savings that may be paid to an ACO under this paragraph.

"(3) MONITORING AVOIDANCE OF AT-RISK PATIENTS.—If the Secretary determines that an ACO has taken steps to avoid patients at risk in order to reduce the likelihood of increasing costs to the ACO the Secretary may impose an appropriate sanction on the ACO, including termination from the program.

1 "(4) TERMINATION.—The Secretary may termi-
2 nate an agreement with an ACO if it does not meet
3 the quality performance standards established by the
4 Secretary under subsection (b)(3).
5 "(e) ADMINISTRATION.—Chapter 35 of title 44,
6 United States Code, shall not apply to the program.
7 "(f) WAIVER AUTHORITY.—The Secretary may waive
8 such requirements of sections 1128A and 1128B and title
9 XVIII of this Act as may be necessary to carry out the
10 provisions of this section.
11 "(g) LIMITATIONS ON REVIEW.—There shall be no
12 administrative or judicial review under section 1869, sec-
13 tion 1878, or otherwise of—
14 "(1) the specification of criteria under sub-
15 section (a)(1)(B);
16 "(2) the assessment of the quality of care fur-
17 nished by an ACO and the establishment of perform-
18 ance standards under subsection (b)(3);
19 "(3) the assignment of Medicare fee-for-service
20 beneficiaries to an ACO under subsection (c);
21 "(4) the determination of whether an ACO is
22 eligible for shared savings under subsection (d)(2)
23 and the amount of such shared savings, including
24 the determination of the estimated average per cap-
25 ita Medicare expenditures under the ACO for Medi-

1 care fee-for-service beneficiaries assigned to the ACO
2 and the average benchmark for the ACO under sub-
3 section (d)(1)(B);
4 "(5) the percent of shared savings specified by
5 the Secretary under subsection (d)(2) and any limit
6 on the total amount of shared savings established by
7 the Secretary under such subsection; and
8 "(6) the termination of an ACO under sub-
9 section (d)(4).
10 "(h) DEFINITIONS.—In this section:
11 "(1) ACO PROFESSIONAL.—The term 'ACO
12 professional' means—
13 "(A) a physician (as defined in section
14 1861(r)(1)); and
15 "(B) a practitioner described in section
16 1842(b)(18)(C)(i).
17 "(2) HOSPITAL.—The term 'hospital' means a
18 subsection (d) hospital (as defined in section
19 1886(d)(1)(B)).
20 "(3) MEDICARE FEE-FOR-SERVICE BENE-
21 FICIARY.—The term 'Medicare fee-for-service bene-
22 ficiary' means an individual who is enrolled in the
23 original Medicare fee-for-service program under
24 parts A and B and is not enrolled in an MA plan

1 under part C, an eligible organization under section
2 1876, or a PACE program under section 1894.''.

3 **SEC. 3023. NATIONAL PILOT PROGRAM ON PAYMENT BUN-**
4 **DLING.**

5 Title XVIII of the Social Security Act, as amended
6 by section 3021, is amended by inserting after section
7 1886C the following new section:

8 ''NATIONAL PILOT PROGRAM ON PAYMENT BUNDLING

9 ''SEC. 1866D. (a) IMPLEMENTATION.—

10 ''(1) IN GENERAL.—The Secretary shall estab-
11 lish a pilot program for integrated care during an
12 episode of care provided to an applicable beneficiary
13 around a hospitalization in order to improve the co-
14 ordination, quality, and efficiency of health care
15 services under this title.

16 ''(2) DEFINITIONS.—In this section:

17 ''(A) APPLICABLE BENEFICIARY.—The
18 term 'applicable beneficiary' means an indi-
19 vidual who—

20 ''(i) is entitled to, or enrolled for, ben-
21 efits under part A and enrolled for benefits
22 under part B of such title, but not enrolled
23 under part C or a PACE program under
24 section 1894; and

25 ''(ii) is admitted to a hospital for an
26 applicable condition.

1 "(B) APPLICABLE CONDITION.—The term
2 'applicable condition' means 1 or more of 8 con-
3 ditions selected by the Secretary. In selecting
4 conditions under the preceding sentence, the
5 Secretary shall take into consideration the fol-
6 lowing factors:
7 "(i) Whether the conditions selected
8 include a mix of chronic and acute condi-
9 tions.
10 "(ii) Whether the conditions selected
11 include a mix of surgical and medical con-
12 ditions.
13 "(iii) Whether a condition is one for
14 which there is evidence of an opportunity
15 for providers of services and suppliers to
16 improve the quality of care furnished while
17 reducing total expenditures under this
18 title.
19 "(iv) Whether a condition has signifi-
20 cant variation in—
21 "(I) the number of readmissions;
22 and
23 "(II) the amount of expenditures
24 for post-acute care spending under
25 this title.

1 "(v) Whether a condition is high-vol-
2 ume and has high post-acute care expendi-
3 tures under this title.
4 "(vi) Which conditions the Secretary
5 determines are most amenable to bundling
6 across the spectrum of care given practice
7 patterns under this title.
8 "(C) APPLICABLE SERVICES.—The term
9 'applicable services' means the following:
10 "(i) Acute care inpatient services.
11 "(ii) Physicians' services delivered in
12 and outside of an acute care hospital set-
13 ting.
14 "(iii) Outpatient hospital services, in-
15 cluding emergency department services.
16 "(iv) Post-acute care services, includ-
17 ing home health services, skilled nursing
18 services, inpatient rehabilitation services,
19 and inpatient hospital services furnished by
20 a long-term care hospital.
21 "(v) Other services the Secretary de-
22 termines appropriate.
23 "(D) EPISODE OF CARE.—
24 "(i) IN GENERAL.—Subject to clause
25 (ii), the term 'episode of care' means, with

respect to an applicable condition and an applicable beneficiary, the period that includes—

"(I) the 3 days prior to the admission of the applicable beneficiary to a hospital for the applicable condition;

"(II) the length of stay of the applicable beneficiary in such hospital; and

"(III) the 30 days following the discharge of the applicable beneficiary from such hospital.

"(ii) ESTABLISHMENT OF PERIOD BY THE SECRETARY.—The Secretary, as appropriate, may establish a period (other than the period described in clause (i)) for an episode of care under the pilot program.

"(E) PHYSICIANS' SERVICES.—The term 'physicians' services' has the meaning given such term in section 1861(q).

"(F) PILOT PROGRAM.—The term 'pilot program' means the pilot program under this section.

1 "(G) PROVIDER OF SERVICES.—The term
2 'provider of services' has the meaning given
3 such term in section 1861(u).
4 "(H) READMISSION.—The term 'readmis-
5 sion' has the meaning given such term in sec-
6 tion 1886(q)(5)(E).
7 "(I) SUPPLIER.—The term 'supplier' has
8 the meaning given such term in section
9 1861(d).
10 "(3) DEADLINE FOR IMPLEMENTATION.—The
11 Secretary shall establish the pilot program not later
12 than January 1, 2013.
13 "(b) DEVELOPMENTAL PHASE.—
14 "(1) DETERMINATION OF PATIENT ASSESS-
15 MENT INSTRUMENT.—The Secretary shall determine
16 which patient assessment instrument (such as the
17 Continuity Assessment Record and Evaluation
18 (CARE) tool) shall be used under the pilot program
19 to evaluate the applicable condition of an applicable
20 beneficiary for purposes of determining the most
21 clinically appropriate site for the provision of post-
22 acute care to the applicable beneficiary.
23 "(2) DEVELOPMENT OF QUALITY MEASURES
24 FOR AN EPISODE OF CARE AND FOR POST-ACUTE
25 CARE.—

"(A) IN GENERAL.—The Secretary, in consultation with the Agency for Healthcare Research and Quality and the entity with a contract under section 1890(a) of the Social Security Act, shall develop quality measures for use in the pilot program—

"(i) for episodes of care; and

"(ii) for post-acute care.

"(B) SITE-NEUTRAL POST-ACUTE CARE QUALITY MEASURES.—Any quality measures developed under subparagraph (A)(ii) shall be site-neutral.

"(C) COORDINATION WITH QUALITY MEASURE DEVELOPMENT AND ENDORSEMENT PROCEDURES.—The Secretary shall ensure that the development of quality measures under subparagraph (A) is done in a manner that is consistent with the measures developed and endorsed under section 1890 and 1890A that are applicable to all post-acute care settings.

"(c) DETAILS.—

"(1) DURATION.—

"(A) IN GENERAL.—Subject to subparagraph (B), the pilot program shall be conducted for a period of 5 years.

1 "(B) EXTENSION.—The Secretary may ex-
2 tend the duration of the pilot program for pro-
3 viders of services and suppliers participating in
4 the pilot program as of the day before the end
5 of the 5-year period described in subparagraph
6 (A), for a period determined appropriate by the
7 Secretary, if the Secretary determines that such
8 extension will result in improving or not reduc-
9 ing the quality of patient care and reducing
10 spending under this title.
11 "(2) PARTICIPATING PROVIDERS OF SERVICES
12 AND SUPPLIERS.—
13 "(A) IN GENERAL.—An entity comprised
14 of providers of services and suppliers, including
15 a hospital, a physician group, a skilled nursing
16 facility, and a home health agency, who are oth-
17 erwise participating under this title, may sub-
18 mit an application to the Secretary to provide
19 applicable services to applicable individuals
20 under this section.
21 "(B) REQUIREMENTS.—The Secretary
22 shall develop requirements for entities to par-
23 ticipate in the pilot program under this section.
24 Such requirements shall ensure that applicable
25 beneficiaries have an adequate choice of pro-

1 viders of services and suppliers under the pilot
2 program.
3 "(3) PAYMENT METHODOLOGY.—
4 "(A) IN GENERAL.—
5 "(i) ESTABLISHMENT OF PAYMENT
6 METHODS.—The Secretary shall develop
7 payment methods for the pilot program for
8 entities participating in the pilot program.
9 Such payment methods may include bun-
10 dled payments and bids from entities for
11 episodes of care. The Secretary shall make
12 payments to the entity for services covered
13 under this section.
14 "(ii) NO ADDITIONAL PROGRAM EX-
15 PENDITURES.—Payments under this sec-
16 tion for applicable items and services under
17 this title (including payment for services
18 described in subparagraph (B)) for appli-
19 cable beneficiaries for a year shall be es-
20 tablished in a manner that does not result
21 in spending more for such entity for such
22 beneficiaries than would otherwise be ex-
23 pended for such entity for such bene-
24 ficiaries for such year if the pilot program

1 were not implemented, as estimated by the
2 Secretary.
3 "(B) INCLUSION OF CERTAIN SERVICES.—
4 A payment methodology tested under the pilot
5 program shall include payment for the fur-
6 nishing of applicable services and other appro-
7 priate services, such as care coordination, medi-
8 cation reconciliation, discharge planning, transi-
9 tional care services, and other patient-centered
10 activities as determined appropriate by the Sec-
11 retary.
12 "(C) BUNDLED PAYMENTS.—
13 "(i) IN GENERAL.—A bundled pay-
14 ment under the pilot program shall—
15 "(I) be comprehensive, covering
16 the costs of applicable services and
17 other appropriate services furnished to
18 an individual during an episode of
19 care (as determined by the Secretary);
20 and
21 "(II) be made to the entity which
22 is participating in the pilot program.
23 "(ii) REQUIREMENT FOR PROVISION
24 OF APPLICABLE SERVICES AND OTHER AP-
25 PROPRIATE SERVICES.—Applicable services

and other appropriate services for which payment is made under this subparagraph shall be furnished or directed by the entity which is participating in the pilot program.

"(D) PAYMENT FOR POST-ACUTE CARE SERVICES AFTER THE EPISODE OF CARE.—The Secretary shall establish procedures, in the case where an applicable beneficiary requires continued post-acute care services after the last day of the episode of care, under which payment for such services shall be made.

"(4) QUALITY MEASURES.—

"(A) IN GENERAL.—The Secretary shall establish quality measures (including quality measures of process, outcome, and structure) related to care provided by entities participating in the pilot program. Quality measures established under the preceding sentence shall include measures of the following:

"(i) Functional status improvement.

"(ii) Reducing rates of avoidable hospital readmissions.

"(iii) Rates of discharge to the community.

1 "(iv) Rates of admission to an emer-
2 gency room after a hospitalization.
3 "(v) Incidence of health care acquired
4 infections.
5 "(vi) Efficiency measures.
6 "(vii) Measures of patient-
7 centeredness of care.
8 "(viii) Measures of patient perception
9 of care.
10 "(ix) Other measures, including meas-
11 ures of patient outcomes, determined ap-
12 propriate by the Secretary.
13 "(B) REPORTING ON QUALITY MEAS-
14 URES.—
15 "(i) IN GENERAL.—A entity shall sub-
16 mit data to the Secretary on quality meas-
17 ures established under subparagraph (A)
18 during each year of the pilot program (in
19 a form and manner, subject to clause (iii),
20 specified by the Secretary).
21 "(ii) SUBMISSION OF DATA THROUGH
22 ELECTRONIC HEALTH RECORD.—To the
23 extent practicable, the Secretary shall
24 specify that data on measures be sub-
25 mitted under clause (i) through the use of

1 an qualified electronic health record (as de-
2 fined in section 3000(13) of the Public
3 Health Service Act (42 U.S.C. 300jj–
4 11(13)) in a manner specified by the Sec-
5 retary.
6 "(d) WAIVER.—The Secretary may waive such provi-
7 sions of this title and title XI as may be necessary to carry
8 out the pilot program.
9 "(e) INDEPENDENT EVALUATION AND REPORTS ON
10 PILOT PROGRAM.—
11 "(1) INDEPENDENT EVALUATION.—The Sec-
12 retary shall conduct an independent evaluation of
13 the pilot program, including the extent to which the
14 pilot program has—
15 "(A) improved quality measures estab-
16 lished under subsection (c)(4)(A);
17 "(B) improved health outcomes;
18 "(C) improved applicable beneficiary access
19 to care; and
20 "(D) reduced spending under this title.
21 "(2) REPORTS.—
22 "(A) INTERIM REPORT.—Not later than 2
23 years after the implementation of the pilot pro-
24 gram, the Secretary shall submit to Congress a

1 report on the initial results of the independent
2 evaluation conducted under paragraph (1).
3 "(B) FINAL REPORT.—Not later than 3
4 years after the implementation of the pilot pro-
5 gram, the Secretary shall submit to Congress a
6 report on the final results of the independent
7 evaluation conducted under paragraph (1).
8 "(f) CONSULTATION.—The Secretary shall consult
9 with representatives of small rural hospitals, including
10 critical access hospitals (as defined in section
11 1861(mm)(1)), regarding their participation in the pilot
12 program. Such consultation shall include consideration of
13 innovative methods of implementing bundled payments in
14 hospitals described in the preceding sentence, taking into
15 consideration any difficulties in doing so as a result of the
16 low volume of services provided by such hospitals.
17 "(g) IMPLEMENTATION PLAN.—
18 "(1) IN GENERAL.—Not later than January 1,
19 2016, the Secretary shall submit a plan for the im-
20 plementation of an expansion of the pilot program if
21 the Secretary determines that such expansion will
22 result in improving or not reducing the quality of
23 patient care and reducing spending under this title.
24 "(h) ADMINISTRATION.—Chapter 35 of title 44,
25 United States Code, shall not apply to the selection, test-

ing, and evaluation of models or the expansion of such models under this section.''.

SEC. 3024. INDEPENDENCE AT HOME DEMONSTRATION PROGRAM.

Title XVIII of the Social Security Act is amended by inserting after section 1866D, as inserted by section 3023, the following new section:

''INDEPENDENCE AT HOME MEDICAL PRACTICE DEMONSTRATION PROGRAM

''SEC. 1866D. (a) ESTABLISHMENT.—

''(1) IN GENERAL.—The Secretary shall conduct a demonstration program (in this section referred to as the 'demonstration program') to test a payment incentive and service delivery model that utilizes physician and nurse practitioner directed home-based primary care teams designed to reduce expenditures and improve health outcomes in the provision of items and services under this title to applicable beneficiaries (as defined in subsection (d)).

''(2) REQUIREMENT.—The demonstration program shall test whether a model described in paragraph (1), which is accountable for providing comprehensive, coordinated, continuous, and accessible care to high-need populations at home and coordinating health care across all treatment settings, results in—

1 "(A) reducing preventable hospitalizations;
2 "(B) preventing hospital readmissions;
3 "(C) reducing emergency room visits;
4 "(D) improving health outcomes commen-
5 surate with the beneficiaries' stage of chronic
6 illness;
7 "(E) improving the efficiency of care, such
8 as by reducing duplicative diagnostic and lab-
9 oratory tests;
10 "(F) reducing the cost of health care serv-
11 ices covered under this title; and
12 "(G) achieving beneficiary and family care-
13 giver satisfaction.
14 "(b) INDEPENDENCE AT HOME MEDICAL PRAC-
15 TICE.—
16 "(1) INDEPENDENCE AT HOME MEDICAL PRAC-
17 TICE DEFINED.—In this section:
18 "(A) IN GENERAL.—The term 'independ-
19 ence at home medical practice' means a legal
20 entity that—
21 "(i) is comprised of an individual phy-
22 sician or nurse practitioner or group of
23 physicians and nurse practitioners that
24 provides care as part of a team that in-
25 cludes physicians, nurses, physician assist-

ants, pharmacists, and other health and social services staff as appropriate who have experience providing home-based primary care to applicable beneficiaries, make in-home visits, and are available 24 hours per day, 7 days per week to carry out plans of care that are tailored to the individual beneficiary's chronic conditions and designed to achieve the results in subsection (a);

''(ii) is organized at least in part for the purpose of providing physicians' services;

''(iii) has documented experience in providing home-based primary care services to high-cost chronically ill beneficiaries, as determined appropriate by the Secretary;

''(iv) furnishes services to at least 200 applicable beneficiaries (as defined in subsection (d)) during each year of the demonstration program;

''(v) has entered into an agreement with the Secretary;

1 "(vi) uses electronic health informa-
2 tion systems, remote monitoring, and mo-
3 bile diagnostic technology; and
4 "(vii) meets such other criteria as the
5 Secretary determines to be appropriate to
6 participate in the demonstration program.
7 The entity shall report on quality measures (in
8 such form, manner, and frequency as specified
9 by the Secretary, which may be for the group,
10 for providers of services and suppliers, or both)
11 and report to the Secretary (in a form, manner,
12 and frequency as specified by the Secretary)
13 such data as the Secretary determines appro-
14 priate to monitor and evaluate the demonstra-
15 tion program.
16 "(B) PHYSICIAN.—The term 'physician' in-
17 cludes, except as the Secretary may otherwise
18 provide, any individual who furnishes services
19 for which payment may be made as physicians'
20 services and has the medical training or experi-
21 ence to fulfill the physician's role described in
22 subparagraph (A)(i).
23 "(2) PARTICIPATION OF NURSE PRACTITIONERS
24 AND PHYSICIAN ASSISTANTS.—Nothing in this sec-
25 tion shall be construed to prevent a nurse practi-

1 tioner or physician assistant from participating in,
2 or leading, a home-based primary care team as part
3 of an independence at home medical practice if—
4 "(A) all the requirements of this section
5 are met;
6 "(B) the nurse practitioner or physician
7 assistant, as the case may be, is acting con-
8 sistent with State law; and
9 "(C) the nurse practitioner or physician
10 assistant has the medical training or experience
11 to fulfill the nurse practitioner or physician as-
12 sistant role described in paragraph (1)(A)(i).
13 "(3) INCLUSION OF PROVIDERS AND PRACTI-
14 TIONERS.—Nothing in this subsection shall be con-
15 strued as preventing an independence at home med-
16 ical practice from including a provider of services or
17 a participating practitioner described in section
18 1842(b)(18)(C) that is affiliated with the practice
19 under an arrangement structured so that such pro-
20 vider of services or practitioner participates in the
21 demonstration program and shares in any savings
22 under the demonstration program.
23 "(4) QUALITY AND PERFORMANCE STAND-
24 ARDS.—The Secretary shall develop quality perform-
25 ance standards for independence at home medical

1 practices participating in the demonstration pro-
2 gram.
3 "(c) PAYMENT METHODOLOGY.—
4 "(1) ESTABLISHMENT OF TARGET SPENDING
5 LEVEL.—The Secretary shall establish an estimated
6 annual spending target, for the amount the Sec-
7 retary estimates would have been spent in the ab-
8 sence of the demonstration, for items and services
9 covered under parts A and B furnished to applicable
10 beneficiaries for each qualifying independence at
11 home medical practice under this section. Such
12 spending targets shall be determined on a per capita
13 basis. Such spending targets shall include a risk cor-
14 ridor that takes into account normal variation in ex-
15 penditures for items and services covered under
16 parts A and B furnished to such beneficiaries with
17 the size of the corridor being related to the number
18 of applicable beneficiaries furnished services by each
19 independence at home medical practice. The spend-
20 ing targets may also be adjusted for other factors as
21 the Secretary determines appropriate.
22 "(2) INCENTIVE PAYMENTS.—Subject to per-
23 formance on quality measures, a qualifying inde-
24 pendence at home medical practice is eligible to re-
25 ceive an incentive payment under this section if ac-

1 tual expenditures for a year for the applicable bene-
2 ficiaries it enrolls are less than the estimated spend-
3 ing target established under paragraph (1) for such
4 year. An incentive payment for such year shall be
5 equal to a portion (as determined by the Secretary)
6 of the amount by which actual expenditures (includ-
7 ing incentive payments under this paragraph) for
8 applicable beneficiaries under parts A and B for
9 such year are estimated to be less than 5 percent
10 less than the estimated spending target for such
11 year, as determined under paragraph (1).
12 ''(d) APPLICABLE BENEFICIARIES.—
13 ''(1) DEFINITION.—In this section, the term
14 'applicable beneficiary' means, with respect to a
15 qualifying independence at home medical practice,
16 an individual who the practice has determined—
17 ''(A) is entitled to benefits under part A
18 and enrolled for benefits under part B;
19 ''(B) is not enrolled in a Medicare Advan-
20 tage plan under part C or a PACE program
21 under section 1894;
22 ''(C) has 2 or more chronic illnesses, such
23 as congestive heart failure, diabetes, other de-
24 mentias designated by the Secretary, chronic
25 obstructive pulmonary disease, ischemic heart

disease, stroke, Alzheimer's Disease and neurodegenerative diseases, and other diseases and conditions designated by the Secretary which result in high costs under this title;

"(D) within the past 12 months has had a nonelective hospital admission;

"(E) within the past 12 months has received acute or subacute rehabilitation services;

"(F) has 2 or more functional dependencies requiring the assistance of another person (such as bathing, dressing, toileting, walking, or feeding); and

"(G) meets such other criteria as the Secretary determines appropriate.

"(2) PATIENT ELECTION TO PARTICIPATE.—The Secretary shall determine an appropriate method of ensuring that applicable beneficiaries have agreed to enroll in an independence at home medical practice under the demonstration program. Enrollment in the demonstration program shall be voluntary.

"(3) BENEFICIARY ACCESS TO SERVICES.—Nothing in this section shall be construed as encouraging physicians or nurse practitioners to limit applicable beneficiary access to services covered under

1 this title and applicable beneficiaries shall not be re-
2 quired to relinquish access to any benefit under this
3 title as a condition of receiving services from an
4 independence at home medical practice.
5 ''(e) IMPLEMENTATION.—
6 ''(1) STARTING DATE.—The demonstration pro-
7 gram shall begin no later than January 1, 2012. An
8 agreement with an independence at home medical
9 practice under the demonstration program may
10 cover not more than a 3-year period.
11 ''(2) NO PHYSICIAN DUPLICATION IN DEM-
12 ONSTRATION PARTICIPATION.—The Secretary shall
13 not pay an independence at home medical practice
14 under this section that participates in section 1899.
15 ''(3) NO BENEFICIARY DUPLICATION IN DEM-
16 ONSTRATION PARTICIPATION.—The Secretary shall
17 ensure that no applicable beneficiary enrolled in an
18 independence at home medical practice under this
19 section is participating in the programs under sec-
20 tion 1899.
21 ''(4) PREFERENCE.—In approving an independ-
22 ence at home medical practice, the Secretary shall
23 give preference to practices that are—
24 ''(A) located in high-cost areas of the
25 country;

"(B) have experience in furnishing health care services to applicable beneficiaries in the home; and

"(C) use electronic medical records, health information technology, and individualized plans of care.

"(5) LIMITATION ON NUMBER OF PRACTICES.—In selecting qualified independence at home medical practices to participate under the demonstration program, the Secretary shall limit the number of such practices so that the number of applicable beneficiaries that may participate in the demonstration program does not exceed 10,000.

"(6) WAIVER.—The Secretary may waive such provisions of this title and title XI as the Secretary determines necessary in order to implement the demonstration program.

"(7) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to this section.

"(f) EVALUATION AND MONITORING.—

"(1) IN GENERAL.—The Secretary shall evaluate each independence at home medical practice under the demonstration program to assess whether the practice achieved the results described in subsection (a).

1 "(2) MONITORING APPLICABLE BENE-
2 FICIARIES.—The Secretary may monitor data on ex-
3 penditures and quality of services under this title
4 after an applicable beneficiary discontinues receiving
5 services under this title through a qualifying inde-
6 pendence at home medical practice.

7 "(g) REPORTS TO CONGRESS.—The Secretary shall
8 conduct an independent evaluation of the demonstration
9 program and submit to Congress a final report, including
10 best practices under the demonstration program. Such re-
11 port shall include an analysis of the demonstration pro-
12 gram on coordination of care, expenditures under this
13 title, applicable beneficiary access to services, and the
14 quality of health care services provided to applicable bene-
15 ficiaries.

16 "(h) FUNDING.—For purposes of administering and
17 carrying out the demonstration program, other than for
18 payments for items and services furnished under this title
19 and incentive payments under subsection (c), in addition
20 to funds otherwise appropriated, there shall be transferred
21 to the Secretary for the Center for Medicare & Medicaid
22 Services Program Management Account from the Federal
23 Hospital Insurance Trust Fund under section 1817 and
24 the Federal Supplementary Medical Insurance Trust
25 Fund under section 1841 (in proportions determined ap-

propriate by the Secretary) $5,000,000 for each of fiscal years 2010 through 2015. Amounts transferred under this subsection for a fiscal year shall be available until expended.

"(i) TERMINATION.—

"(1) MANDATORY TERMINATION.—The Secretary shall terminate an agreement with an independence at home medical practice if—

"(A) the Secretary estimates or determines that such practice will not receive an incentive payment for the second of 2 consecutive years under the demonstration program; or

"(B) such practice fails to meet quality standards during any year of the demonstration program.

"(2) PERMISSIVE TERMINATION.—The Secretary may terminate an agreement with an independence at home medical practice for such other reasons determined appropriate by the Secretary.".

SEC. 3025. HOSPITAL READMISSIONS REDUCTION PROGRAM.

(a) IN GENERAL.—Section 1886 of the Social Security Act (42 U.S.C. 1395ww), as amended by sections 3001 and 3008, is amended by adding at the end the following new subsection:

1 "(q) HOSPITAL READMISSIONS REDUCTION PRO-
2 GRAM.—
3 "(1) IN GENERAL.—With respect to payment
4 for discharges from an applicable hospital (as de-
5 fined in paragraph (5)(C)) occurring during a fiscal
6 year beginning on or after October 1, 2012, in order
7 to account for excess readmissions in the hospital,
8 the Secretary shall reduce the payments that would
9 otherwise be made to such hospital under subsection
10 (d) (or section 1814(b)(3), as the case may be) for
11 such a discharge by an amount equal to the product
12 of—
13 "(A) the base operating DRG payment
14 amount (as defined in paragraph (2)) for the
15 discharge; and
16 "(B) the adjustment factor (described in
17 paragraph (3)(A)) for the hospital for the fiscal
18 year.
19 "(2) BASE OPERATING DRG PAYMENT AMOUNT
20 DEFINED.—
21 "(A) IN GENERAL.—Except as provided in
22 subparagraph (B), in this subsection, the term
23 'base operating DRG payment amount' means,
24 with respect to a hospital for a fiscal year—

"(i) the payment amount that would otherwise be made under subsection (d) (determined without regard to subsection (o)) for a discharge if this subsection did not apply; reduced by

"(ii) any portion of such payment amount that is attributable to payments under paragraphs (5)(A), (5)(B), (5)(F), and (12) of subsection (d).

"(B) SPECIAL RULES FOR CERTAIN HOSPITALS.—

"(i) SOLE COMMUNITY HOSPITALS AND MEDICARE-DEPENDENT, SMALL RURAL HOSPITALS.—In the case of a medicare-dependent, small rural hospital (with respect to discharges occurring during fiscal years 2012 and 2013) or a sole community hospital, in applying subparagraph (A)(i), the payment amount that would otherwise be made under subsection (d) shall be determined without regard to subparagraphs (I) and (L) of subsection (b)(3) and subparagraphs (D) and (G) of subsection (d)(5).

"(ii) HOSPITALS PAID UNDER SECTION 1814.—In the case of a hospital that is paid under section 1814(b)(3), the Secretary may exempt such hospitals provided that States paid under such section submit an annual report to the Secretary describing how a similar program in the State for a participating hospital or hospitals achieves or surpasses the measured results in terms of patient health outcomes and cost savings established herein with respect to this section.

"(3) ADJUSTMENT FACTOR.—

"(A) IN GENERAL.—For purposes of paragraph (1), the adjustment factor under this paragraph for an applicable hospital for a fiscal year is equal to the greater of—

"(i) the ratio described in subparagraph (B) for the hospital for the applicable period (as defined in paragraph (5)(D)) for such fiscal year; or

"(ii) the floor adjustment factor specified in subparagraph (C).

"(B) RATIO.—The ratio described in this subparagraph for a hospital for an applicable period is equal to 1 minus the ratio of—

"(i) the aggregate payments for excess readmissions (as defined in paragraph (4)(A)) with respect to an applicable hospital for the applicable period; and

"(ii) the aggregate payments for all discharges (as defined in paragraph (4)(B)) with respect to such applicable hospital for such applicable period.

"(C) FLOOR ADJUSTMENT FACTOR.—For purposes of subparagraph (A), the floor adjustment factor specified in this subparagraph for—

"(i) fiscal year 2013 is 0.99;

"(ii) fiscal year 2014 is 0.98; or

"(iii) fiscal year 2015 and subsequent fiscal years is 0.97.

"(4) AGGREGATE PAYMENTS, EXCESS READMISSION RATIO DEFINED.—For purposes of this subsection:

"(A) AGGREGATE PAYMENTS FOR EXCESS READMISSIONS.—The term 'aggregate payments for excess readmissions' means, for a hospital

for an applicable period, the sum, for applicable conditions (as defined in paragraph (5)(A)), of the product, for each applicable condition, of—

"(i) the base operating DRG payment amount for such hospital for such applicable period for such condition;

"(ii) the number of admissions for such condition for such hospital for such applicable period; and

"(iii) the excess readmissions ratio (as defined in subparagraph (C)) for such hospital for such applicable period minus 1.

"(B) AGGREGATE PAYMENTS FOR ALL DISCHARGES.—The term 'aggregate payments for all discharges' means, for a hospital for an applicable period, the sum of the base operating DRG payment amounts for all discharges for all conditions from such hospital for such applicable period.

"(C) EXCESS READMISSION RATIO.—

"(i) IN GENERAL.—Subject to clause (ii), the term 'excess readmissions ratio' means, with respect to an applicable condition for a hospital for an applicable period, the ratio (but not less than 1.0) of—

1 "(I) the risk adjusted readmis-
2 sions based on actual readmissions, as
3 determined consistent with a readmis-
4 sion measure methodology that has
5 been endorsed under paragraph
6 (5)(A)(ii)(I), for an applicable hospital
7 for such condition with respect to
8 such applicable period; to
9 "(II) the risk adjusted expected
10 readmissions (as determined con-
11 sistent with such a methodology) for
12 such hospital for such condition with
13 respect to such applicable period.
14 "(ii) EXCLUSION OF CERTAIN RE-
15 ADMISSIONS.—For purposes of clause (i),
16 with respect to a hospital, excess readmis-
17 sions shall not include readmissions for an
18 applicable condition for which there are
19 fewer than a minimum number (as deter-
20 mined by the Secretary) of discharges for
21 such applicable condition for the applicable
22 period and such hospital.
23 "(5) DEFINITIONS.—For purposes of this sub-
24 section:

"(A) APPLICABLE CONDITION.—The term 'applicable condition' means, subject to subparagraph (B), a condition or procedure selected by the Secretary among conditions and procedures for which—

"(i) readmissions (as defined in subparagraph (E)) that represent conditions or procedures that are high volume or high expenditures under this title (or other criteria specified by the Secretary); and

"(ii) measures of such readmissions—

"(I) have been endorsed by the entity with a contract under section 1890(a); and

"(II) such endorsed measures have exclusions for readmissions that are unrelated to the prior discharge (such as a planned readmission or transfer to another applicable hospital).

"(B) EXPANSION OF APPLICABLE CONDITIONS.—Beginning with fiscal year 2015, the Secretary shall, to the extent practicable, expand the applicable conditions beyond the 3 conditions for which measures have been en-

1 dorsed as described in subparagraph (A)(ii)(I)
2 as of the date of the enactment of this sub-
3 section to the additional 4 conditions that have
4 been identified by the Medicare Payment Advi-
5 sory Commission in its report to Congress in
6 June 2007 and to other conditions and proce-
7 dures as determined appropriate by the Sec-
8 retary. In expanding such applicable conditions,
9 the Secretary shall seek the endorsement de-
10 scribed in subparagraph (A)(ii)(I) but may
11 apply such measures without such an endorse-
12 ment in the case of a specified area or medical
13 topic determined appropriate by the Secretary
14 for which a feasible and practical measure has
15 not been endorsed by the entity with a contract
16 under section 1890(a) as long as due consider-
17 ation is given to measures that have been en-
18 dorsed or adopted by a consensus organization
19 identified by the Secretary.
20 "(C) APPLICABLE HOSPITAL.—The term
21 'applicable hospital' means a subsection (d) hos-
22 pital or a hospital that is paid under section
23 1814(b)(3), as the case may be.

1 "(D) APPLICABLE PERIOD.—The term 'ap-
2 plicable period' means, with respect to a fiscal
3 year, such period as the Secretary shall specify.
4 "(E) READMISSION.—The term 'readmis-
5 sion' means, in the case of an individual who is
6 discharged from an applicable hospital, the ad-
7 mission of the individual to the same or another
8 applicable hospital within a time period speci-
9 fied by the Secretary from the date of such dis-
10 charge. Insofar as the discharge relates to an
11 applicable condition for which there is an en-
12 dorsed measure described in subparagraph
13 (A)(ii)(I), such time period (such as 30 days)
14 shall be consistent with the time period speci-
15 fied for such measure.
16 "(6) REPORTING HOSPITAL SPECIFIC INFORMA-
17 TION.—
18 "(A) IN GENERAL.—The Secretary shall
19 make information available to the public re-
20 garding readmission rates of each subsection
21 (d) hospital under the program.
22 "(B) OPPORTUNITY TO REVIEW AND SUB-
23 MIT CORRECTIONS.—The Secretary shall ensure
24 that a subsection (d) hospital has the oppor-
25 tunity to review, and submit corrections for, the

information to be made public with respect to the hospital under subparagraph (A) prior to such information being made public.

"(C) WEBSITE.—Such information shall be posted on the Hospital Compare Internet website in an easily understandable format.

"(7) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the following:

"(A) The determination of base operating DRG payment amounts.

"(B) The methodology for determining the adjustment factor under paragraph (3), including excess readmissions ratio under paragraph (4)(C), aggregate payments for excess readmissions under paragraph (4)(A), and aggregate payments for all discharges under paragraph (4)(B), and applicable periods and applicable conditions under paragraph (5).

"(C) The measures of readmissions as described in paragraph (5)(A)(ii).

"(8) READMISSION RATES FOR ALL PATIENTS.—

"(A) CALCULATION OF READMISSION.—The Secretary shall calculate readmission rates

1 for all patients (as defined in subparagraph
2 (D)) for a specified hospital (as defined in sub-
3 paragraph (D)(ii)) for an applicable condition
4 (as defined in paragraph (5)(B)) and other con-
5 ditions deemed appropriate by the Secretary for
6 an applicable period (as defined in paragraph
7 (5)(D)) in the same manner as used to cal-
8 culate such readmission rates for hospitals with
9 respect to this title and posted on the CMS
10 Hospital Compare website.

11 "(B) POSTING OF HOSPITAL SPECIFIC ALL
12 PATIENT READMISSION RATES.—The Secretary
13 shall make information on all patient readmis-
14 sion rates calculated under subparagraph (A)
15 available on the CMS Hospital Compare website
16 in a form and manner determined appropriate
17 by the Secretary. The Secretary may also make
18 other information determined appropriate by
19 the Secretary available on such website.

20 "(C) HOSPITAL SUBMISSION OF ALL PA-
21 TIENT DATA.—

22 "(i) Except as provided for in clause
23 (ii), each specified hospital (as defined in
24 subparagraph (D)(ii)) shall submit to the
25 Secretary, in a form, manner and time

1 specified by the Secretary, data and infor-
2 mation determined necessary by the Sec-
3 retary for the Secretary to calculate the all
4 patient readmission rates described in sub-
5 paragraph (A).

6 ''(ii) Instead of a specified hospital
7 submitting to the Secretary the data and
8 information described in clause (i), such
9 data and information may be submitted to
10 the Secretary, on behalf of such a specified
11 hospital, by a state or an entity determined
12 appropriate by the Secretary.

13 ''(D) DEFINITIONS.—For purposes of this
14 paragraph:

15 ''(i) The term 'all patients' means pa-
16 tients who are treated on an inpatient
17 basis and discharged from a specified hos-
18 pital (as defined in clause (ii)).

19 ''(ii) The term 'specified hospital'
20 means a subsection (d) hospital, hospitals
21 described in clauses (i) through (v) of sub-
22 section (d)(1)(B) and, as determined fea-
23 sible and appropriate by the Secretary,
24 other hospitals not otherwise described in
25 this subparagraph.''.

(b) QUALITY IMPROVEMENT.—Part S of title III of the Public Health Service Act, as amended by section 3015, is further amended by adding at the end the following:

"SEC. 399KK. QUALITY IMPROVEMENT PROGRAM FOR HOSPITALS WITH A HIGH SEVERITY ADJUSTED READMISSION RATE.

"(a) ESTABLISHMENT.—

"(1) IN GENERAL.—Not later than 2 years after the date of enactment of this section, the Secretary shall make available a program for eligible hospitals to improve their readmission rates through the use of patient safety organizations (as defined in section 921(4)).

"(2) ELIGIBLE HOSPITAL DEFINED.—In this subsection, the term 'eligible hospital' means a hospital that the Secretary determines has a high rate of risk adjusted readmissions for the conditions described in section 1886(q)(8)(A) of the Social Security Act and has not taken appropriate steps to reduce such readmissions and improve patient safety as evidenced through historically high rates of readmissions, as determined by the Secretary.

"(3) RISK ADJUSTMENT.—The Secretary shall utilize appropriate risk adjustment measures to determine eligible hospitals.

"(b) REPORT TO THE SECRETARY.—As determined appropriate by the Secretary, eligible hospitals and patient safety organizations working with those hospitals shall report to the Secretary on the processes employed by the hospital to improve readmission rates and the impact of such processes on readmission rates.".

SEC. 3026. COMMUNITY-BASED CARE TRANSITIONS PROGRAM.

(a) IN GENERAL.—The Secretary shall establish a Community-Based Care Transitions Program under which the Secretary provides funding to eligible entities that furnish improved care transition services to high-risk Medicare beneficiaries.

(b) DEFINITIONS.—In this section:

(1) ELIGIBLE ENTITY.—The term "eligible entity" means the following:

(A) A subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B))) identified by the Secretary as having a high readmission rate, such as under section 1886(q) of the Social Security Act, as added by section 3025.

(B) An appropriate community-based organization that provides care transition services under this section across a continuum of care through arrangements with subsection (d) hospitals (as so defined) to furnish the services described in subsection (c)(2)(B)(i) and whose governing body includes sufficient representation of multiple health care stakeholders (including consumers).

(2) HIGH-RISK MEDICARE BENEFICIARY.—The term ''high-risk Medicare beneficiary'' means a Medicare beneficiary who has attained a minimum hierarchical condition category score, as determined by the Secretary, based on a diagnosis of multiple chronic conditions or other risk factors associated with a hospital readmission or substandard transition into post-hospitalization care, which may include 1 or more of the following:

(A) Cognitive impairment.

(B) Depression.

(C) A history of multiple readmissions.

(D) Any other chronic disease or risk factor as determined by the Secretary.

(3) MEDICARE BENEFICIARY.—The term ''Medicare beneficiary'' means an individual who is

1 entitled to benefits under part A of title XVIII of
2 the Social Security Act (42 U.S.C. 1395 et seq.) and
3 enrolled under part B of such title, but not enrolled
4 under part C of such title.

5 (4) PROGRAM.—The term ''program'' means
6 the program conducted under this section.

7 (5) READMISSION.—The term ''readmission''
8 has the meaning given such term in section
9 1886(q)(5)(E) of the Social Security Act, as added
10 by section 3025.

11 (6) SECRETARY.—The term ''Secretary'' means
12 the Secretary of Health and Human Services.

13 (c) REQUIREMENTS.—

14 (1) DURATION.—

15 (A) IN GENERAL.—The program shall be
16 conducted for a 5-year period, beginning Janu-
17 ary 1, 2011.

18 (B) EXPANSION.—The Secretary may ex-
19 pand the duration and the scope of the pro-
20 gram, to the extent determined appropriate by
21 the Secretary, if the Secretary determines (and
22 the Chief Actuary of the Centers for Medicare
23 & Medicaid Services, with respect to spending
24 under this title, certifies) that such expansion

1 would reduce spending under this title without
2 reducing quality.
3 (2) APPLICATION; PARTICIPATION.—
4 (A) IN GENERAL.—
5 (i) APPLICATION.—An eligible entity
6 seeking to participate in the program shall
7 submit an application to the Secretary at
8 such time, in such manner, and containing
9 such information as the Secretary may re-
10 quire.
11 (ii) PARTNERSHIP.—If an eligible en-
12 tity is a hospital, such hospital shall enter
13 into a partnership with a community-based
14 organization to participate in the program.
15 (B) INTERVENTION PROPOSAL.—Subject
16 to subparagraph (C), an application submitted
17 under subparagraph (A)(i) shall include a de-
18 tailed proposal for at least 1 care transition
19 intervention, which may include the following:
20 (i) Initiating care transition services
21 for a high-risk Medicare beneficiary not
22 later than 24 hours prior to the discharge
23 of the beneficiary from the eligible entity.
24 (ii) Arranging timely post-discharge
25 follow-up services to the high-risk Medicare

1 beneficiary to provide the beneficiary (and,
2 as appropriate, the primary caregiver of
3 the beneficiary) with information regarding
4 responding to symptoms that may indicate
5 additional health problems or a deterio-
6 rating condition.
7 (iii) Providing the high-risk Medicare
8 beneficiary (and, as appropriate, the pri-
9 mary caregiver of the beneficiary) with as-
10 sistance to ensure productive and timely
11 interactions between patients and post-
12 acute and outpatient providers.
13 (iv) Assessing and actively engaging
14 with a high-risk Medicare beneficiary (and,
15 as appropriate, the primary caregiver of
16 the beneficiary) through the provision of
17 self-management support and relevant in-
18 formation that is specific to the bene-
19 ficiary's condition.
20 (v) Conducting comprehensive medica-
21 tion review and management (including, if
22 appropriate, counseling and self-manage-
23 ment support).
24 (C) LIMITATION.—A care transition inter-
25 vention proposed under subparagraph (B) may

not include payment for services required under the discharge planning process described in section 1861(ee) of the Social Security Act (42 U.S.C. 1395x(ee)).

(3) SELECTION.—In selecting eligible entities to participate in the program, the Secretary shall give priority to eligible entities that—

(A) participate in a program administered by the Administration on Aging to provide concurrent care transitions interventions with multiple hospitals and practitioners; or

(B) provide services to medically underserved populations, small communities, and rural areas.

(d) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary may implement the provisions of this section by program instruction or otherwise.

(e) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act as may be necessary to carry out the program.

(f) FUNDING.—For purposes of carrying out this section, the Secretary of Health and Human Services shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Secu-

1 rity Act (42 U.S.C. 1395i) and the Federal Supple-
2 mentary Medical Insurance Trust Fund under section
3 1841 of such Act (42 U.S.C. 1395t), in such proportion
4 as the Secretary determines appropriate, of $500,000,000,
5 to the Centers for Medicare & Medicaid Services Program
6 Management Account for the period of fiscal years 2011
7 through 2015. Amounts transferred under the preceding
8 sentence shall remain available until expended.

9 **SEC. 3027. EXTENSION OF GAINSHARING DEMONSTRATION.**

10 (a) IN GENERAL.—Subsection (d)(3) of section 5007
11 of the Deficit Reduction Act of 2005 (Public Law 109–
12 171) is amended by inserting ''(or September 30, 2011,
13 in the case of a demonstration project in operation as of
14 October 1, 2008)'' after ''December 31, 2009''.

15 (b) FUNDING.—

16 (1) IN GENERAL.—Subsection (f)(1) of such
17 section is amended by inserting ''and for fiscal year
18 2010, $1,600,000,'' after ''$6,000,000,''.

19 (2) AVAILABILITY.—Subsection (f)(2) of such
20 section is amended by striking ''2010'' and inserting
21 ''2014 or until expended''.

22 (c) REPORTS.—

23 (1) QUALITY IMPROVEMENT AND SAVINGS.—
24 Subsection (e)(3) of such section is amended by

striking "December 1, 2008" and inserting "March 31, 2011".

(2) FINAL REPORT.—Subsection (e)(4) of such section is amended by striking "May 1, 2010" and inserting "March 31, 2013".

Subtitle B—Improving Medicare for Patients and Providers

PART I—ENSURING BENEFICIARY ACCESS TO PHYSICIAN CARE AND OTHER SERVICES

SEC. 3101. INCREASE IN THE PHYSICIAN PAYMENT UPDATE.

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:

"(10) UPDATE FOR 2010.—

"(A) IN GENERAL.—Subject to paragraphs (7)(B), (8)(B), and (9)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2010, the update to the single conversion factor shall be 0.5 percent.

"(B) NO EFFECT ON COMPUTATION OF CONVERSION FACTOR FOR 2011 AND SUBSEQUENT YEARS.—The conversion factor under this subsection shall be computed under para-

graph (1)(A) for 2011 and subsequent years as if subparagraph (A) had never applied.''.

SEC. 3102. EXTENSION OF THE WORK GEOGRAPHIC INDEX FLOOR AND REVISIONS TO THE PRACTICE EXPENSE GEOGRAPHIC ADJUSTMENT UNDER THE MEDICARE PHYSICIAN FEE SCHEDULE.

(a) EXTENSION OF WORK GPCI FLOOR.—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, 2010'' and inserting ''before January 1, 2011''.

(b) PRACTICE EXPENSE GEOGRAPHIC ADJUSTMENT FOR 2010 AND SUBSEQUENT YEARS.—Section 1848(e)(1) of the Social Security Act (42 U.S.C. 1395w4(e)(1)) is amended—

(1) in subparagraph (A), by striking ''and (G)'' and inserting ''(G), and (H)''; and

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

''(H) PRACTICE EXPENSE GEOGRAPHIC ADJUSTMENT FOR 2010 AND SUBSEQUENT YEARS.—

''(i) FOR 2010.—Subject to clause (iii), for services furnished during 2010, the employee wage and rent portions of the practice expense geographic index described in

subparagraph (A)(i) shall reflect ¾ of the difference between the relative costs of employee wages and rents in each of the different fee schedule areas and the national average of such employee wages and rents.

"(ii) FOR 2011.—Subject to clause (iii), for services furnished during 2011, the employee wage and rent portions of the practice expense geographic index described in subparagraph (A)(i) shall reflect ½ of the difference between the relative costs of employee wages and rents in each of the different fee schedule areas and the national average of such employee wages and rents.

"(iii) HOLD HARMLESS.—The practice expense portion of the geographic adjustment factor applied in a fee schedule area for services furnished in 2010 or 2011 shall not, as a result of the application of clause (i) or (ii), be reduced below the practice expense portion of the geographic adjustment factor under subparagraph (A)(i) (as calculated prior to the applica-

1 tion of such clause (i) or (ii), respectively)
2 for such area for such year.
3 "(iv) ANALYSIS.—The Secretary shall
4 analyze current methods of establishing
5 practice expense geographic adjustments
6 under subparagraph (A)(i) and evaluate
7 data that fairly and reliably establishes
8 distinctions in the costs of operating a
9 medical practice in the different fee sched-
10 ule areas. Such analysis shall include an
11 evaluation of the following:
12 "(I) The feasibility of using ac-
13 tual data or reliable survey data devel-
14 oped by medical organizations on the
15 costs of operating a medical practice,
16 including office rents and non-physi-
17 cian staff wages, in different fee
18 schedule areas.
19 "(II) The office expense portion
20 of the practice expense geographic ad-
21 justment described in subparagraph
22 (A)(i), including the extent to which
23 types of office expenses are deter-
24 mined in local markets instead of na-
25 tional markets.

1 "(III) The weights assigned to
2 each of the categories within the prac-
3 tice expense geographic adjustment
4 described in subparagraph (A)(i).
5 "(v) REVISION FOR 2012 AND SUBSE-
6 QUENT YEARS.—As a result of the analysis
7 described in clause (iv), the Secretary
8 shall, not later than January 1, 2012,
9 make appropriate adjustments to the prac-
10 tice expense geographic adjustment de-
11 scribed in subparagraph (A)(i) to ensure
12 accurate geographic adjustments across fee
13 schedule areas, including—
14 "(I) basing the office rents com-
15 ponent and its weight on office ex-
16 penses that vary among fee schedule
17 areas; and
18 "(II) considering a representative
19 range of professional and non-profes-
20 sional personnel employed in a med-
21 ical office based on the use of the
22 American Community Survey data or
23 other reliable data for wage adjust-
24 ments.

Such adjustments shall be made without regard to adjustments made pursuant to clauses (i) and (ii) and shall be made in a budget neutral manner.''.

SEC. 3103. 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 ''December 31, 2009'' and inserting ''December 31, 2010''.

SEC. 3104. EXTENSION OF PAYMENT FOR TECHNICAL COMPONENT OF CERTAIN PHYSICIAN PATHOLOGY SERVICES.

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 (42 U.S.C. 1395w–4 note), section 104 of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395w–4 note), section 104 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173), and section 136 of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275), is amended by striking ''and 2009'' and inserting ''2009, and 2010''.

SEC. 3105. EXTENSION OF AMBULANCE ADD-ONS.

(a) GROUND AMBULANCE.—Section 1834(l)(13)(A) of the Social Security Act (42 U.S.C. 1395m(l)(13)(A)) is amended—

(1) in the matter preceding clause (i)—

(A) by striking ''2007, and for'' and inserting ''2007, for''; and

(B) by striking ''2010'' and inserting ''2010, and for such services furnished on or after April 1, 2010, and before January 1, 2011,''; and

(2) in each of clauses (i) and (ii), by inserting '', and on or after April 1, 2010, and before January 1, 2011'' after ''January 1, 2010'' each place it appears.

(b) AIR AMBULANCE.—Section 146(b)(1) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275) is amended by striking ''December 31, 2009'' and inserting ''December 31, 2009, and during the period beginning on April 1, 2010, and ending on January 1, 2011''.

(c) SUPER RURAL AMBULANCE.—Section 1834(l)(12)(A) of the Social Security Act (42 U.S.C. 1395m(l)(12)(A)) is amended by striking ''2010'' and inserting ''2010, and on or after April 1, 2010, and before January 1, 2011''.

SEC. 3106. EXTENSION OF CERTAIN PAYMENT RULES FOR LONG-TERM CARE HOSPITAL SERVICES AND OF MORATORIUM ON THE ESTABLISHMENT OF CERTAIN HOSPITALS AND FACILITIES.

(a) EXTENSION OF CERTAIN PAYMENT RULES.—Section 114(c) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (42 U.S.C. 1395ww note), as amended by section 4302(a) of the American Recovery and Reinvestment Act (Public Law 111–5), is further amended by striking ''3-year period'' each place it appears and inserting ''4-year period''.

(b) EXTENSION OF MORATORIUM.—Section 114(d)(1) of such Act (42 U.S.C. 1395ww note), in the matter preceding subparagraph (A), is amended by striking ''3-year period'' and inserting ''4-year period''.

SEC. 3107. EXTENSION OF PHYSICIAN FEE SCHEDULE MENTAL HEALTH ADD-ON.

Section 138(a)(1) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275) is amended by striking ''December 31, 2009'' and inserting ''December 31, 2010''.

SEC. 3108. PERMITTING PHYSICIAN ASSISTANTS TO ORDER POST-HOSPITAL EXTENDED CARE SERVICES.

(a) ORDERING POST-HOSPITAL EXTENDED CARE SERVICES.—

(1) IN GENERAL.—Section 1814(a)(2) of the Social Security Act (42 U.S.C. 1395f(a)(2)), in the matter preceding subparagraph (A), is amended by striking ''or clinical nurse specialist'' and inserting '', a clinical nurse specialist, or a physician assistant (as those terms are defined in section 1861(aa)(5))'' after ''nurse practitioner''.

(2) CONFORMING AMENDMENT.—Section 1814(a) of the Social Security Act (42 U.S.C. 1395f(a)) is amended, in the second sentence, by striking ''or clinical nurse specialist'' and inserting ''clinical nurse specialist, or physician assistant'' after ''nurse practitioner,''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 2011.

SEC. 3109. EXEMPTION OF CERTAIN PHARMACIES FROM ACCREDITATION REQUIREMENTS.

(a) IN GENERAL.—Section 1834(a)(20) of the Social Security Act (42 U.S.C. 1395m(a)(20)), as added by section 154(b)(1)(A) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 100–275), is amended—

(1) in subparagraph (F)(i)—

(A) by inserting "and subparagraph (G)" after "clause (ii)"; and

(B) by inserting ", except that the Secretary shall not require a pharmacy to have submitted to the Secretary such evidence of accreditation prior to January 1, 2011" before the semicolon at the end; and

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

"(G) APPLICATION OF ACCREDITATION REQUIREMENT TO CERTAIN PHARMACIES.—

"(i) IN GENERAL.—With respect to items and services furnished on or after January 1, 2011, in implementing quality standards under this paragraph—

"(I) subject to subclause (II), in applying such standards and the accreditation requirement of subparagraph (F)(i) with respect to pharmacies described in clause (ii) furnishing such items and services, such standards and accreditation requirement shall not apply to such pharmacies; and

"(II) the Secretary may apply to such pharmacies an alternative accreditation requirement established by the Secretary if the Secretary determines such alternative accreditation requirement is more appropriate for such pharmacies.

"(ii) PHARMACIES DESCRIBED.—A pharmacy described in this clause is a pharmacy that meets each of the following criteria:

"(I) The total billings by the pharmacy for such items and services under this title are less than 5 percent of total pharmacy sales, as determined based on the average total pharmacy sales for the previous 3 calendar years, 3 fiscal years, or other yearly period specified by the Secretary.

"(II) The pharmacy has been enrolled under section 1866(j) as a supplier of durable medical equipment, prosthetics, orthotics, and supplies, has been issued (which may include the renewal of) a provider number for

at least 5 years, and for which a final adverse action (as defined in section 424.57(a) of title 42, Code of Federal Regulations) has not been imposed in the past 5 years.

"(III) The pharmacy submits to the Secretary an attestation, in a form and manner, and at a time, specified by the Secretary, that the pharmacy meets the criteria described in subclauses (I) and (II). Such attestation shall be subject to section 1001 of title 18, United States Code.

"(IV) The pharmacy agrees to submit materials as requested by the Secretary, or during the course of an audit conducted on a random sample of pharmacies selected annually, to verify that the pharmacy meets the criteria described in subclauses (I) and (II). Materials submitted under the preceding sentence shall include a certification by an accountant on behalf of the pharmacy or the submission of tax returns filed by the phar-

macy during the relevant periods, as requested by the Secretary.''.

(b) ADMINISTRATION.—Notwithstanding any other provision of law, the Secretary may implement the amendments made by subsection (a) by program instruction or otherwise.

(c) RULE OF CONSTRUCTION.—Nothing in the provisions of or amendments made by this section shall be construed as affecting the application of an accreditation requirement for pharmacies to qualify for bidding in a competitive acquisition area under section 1847 of the Social Security Act (42 U.S.C. 1395w–3).

SEC. 3110. PART B SPECIAL ENROLLMENT PERIOD FOR DISABLED TRICARE BENEFICIARIES.

(a) IN GENERAL.—

(1) IN GENERAL.—Section 1837 of the Social Security Act (42 U.S.C. 1395p) is amended by adding at the end the following new subsection:

''(l)(1) In the case of any individual who is a covered beneficiary (as defined in section 1072(5) of title 10, United States Code) at the time the individual is entitled to part A under section 226(b) or section 226A and who is eligible to enroll but who has elected not to enroll (or to be deemed enrolled) during the individual's initial en-

1 rollment period, there shall be a special enrollment period
2 described in paragraph (2).

3 ''(2) The special enrollment period described in this
4 paragraph, with respect to an individual, is the 12-month
5 period beginning on the day after the last day of the initial
6 enrollment period of the individual or, if later, the 12-
7 month period beginning with the month the individual is
8 notified of enrollment under this section.

9 ''(3) In the case of an individual who enrolls during
10 the special enrollment period provided under paragraph
11 (1), the coverage period under this part shall begin on the
12 first day of the month in which the individual enrolls, or,
13 at the option of the individual, the first month after the
14 end of the individual's initial enrollment period.

15 ''(4) An individual may only enroll during the special
16 enrollment period provided under paragraph (1) one time
17 during the individual's lifetime.

18 ''(5) The Secretary shall ensure that the materials
19 relating to coverage under this part that are provided to
20 an individual described in paragraph (1) prior to the indi-
21 vidual's initial enrollment period contain information con-
22 cerning the impact of not enrolling under this part, includ-
23 ing the impact on health care benefits under the
24 TRICARE program under chapter 55 of title 10, United
25 States Code.

"(6) The Secretary of Defense shall collaborate with the Secretary of Health and Human Services and the Commissioner of Social Security to provide for the accurate identification of individuals described in paragraph (1). The Secretary of Defense shall provide such individuals with notification with respect to this subsection. The Secretary of Defense shall collaborate with the Secretary of Health and Human Services and the Commissioner of Social Security to ensure appropriate follow up pursuant to any notification provided under the preceding sentence.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to elections made with respect to initial enrollment periods that end after the date of the enactment of this Act.

(b) WAIVER OF INCREASE OF PREMIUM.—Section 1839(b) of the Social Security Act (42 U.S.C. 1395r(b)) is amended by striking "section 1837(i)(4)" and inserting "subsection (i)(4) or (l) of section 1837".

SEC. 3111. PAYMENT FOR BONE DENSITY TESTS.

(a) PAYMENT.—

(1) IN GENERAL.—Section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended—

(A) in subsection (b)—

(i) in paragraph (4)(B), by inserting ", and for 2010 and 2011, dual-energy x-ray absorptiometry services (as described in paragraph (6))" before the period at the end; and

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

"(6) TREATMENT OF BONE MASS SCANS.—For dual-energy x-ray absorptiometry services (identified in 2006 by HCPCS codes 76075 and 76077 (and any succeeding codes)) furnished during 2010 and 2011, instead of the payment amount that would otherwise be determined under this section for such years, the payment amount shall be equal to 70 percent of the product of—

"(A) the relative value for the service (as determined in subsection (c)(2)) for 2006;

"(B) the conversion factor (established under subsection (d)) for 2006; and

"(C) the geographic adjustment factor (established under subsection (e)(2)) for the service for the fee schedule area for 2010 and 2011, respectively."; and

(B) in subsection (c)(2)(B)(iv)—

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

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

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

"(IV) subsection (b)(6) shall not be taken into account in applying clause (ii)(II) for 2010 or 2011.".

(2) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary may implement the amendments made by paragraph (1) by program instruction or otherwise.

(b) STUDY AND REPORT BY THE INSTITUTE OF MEDICINE.—

(1) IN GENERAL.—The Secretary of Health and Human Services is authorized to enter into an agreement with the Institute of Medicine of the National Academies to conduct a study on the ramifications of Medicare payment reductions for dual-energy x-ray absorptiometry (as described in section 1848(b)(6) of the Social Security Act, as added by subsection (a)(1)) during 2007, 2008, and 2009 on beneficiary access to bone mass density tests.

(2) REPORT.—An agreement entered into under paragraph (1) shall provide for the Institute of Medicine to submit to the Secretary and to Congress a report containing the results of the study conducted under such paragraph.

SEC. 3112. REVISION TO THE MEDICARE IMPROVEMENT FUND.

Section 1898(b)(1)(A) of the Social Security Act (42 U.S.C. 1395iii) is amended by striking ''$22,290,000,000'' and inserting ''$0''.

SEC. 3113. TREATMENT OF CERTAIN COMPLEX DIAGNOSTIC LABORATORY TESTS.

(a) DEMONSTRATION PROJECT.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall conduct a demonstration project under part B title XVIII of the Social Security Act under which separate payments are made under such part for complex diagnostic laboratory tests provided to individuals under such part. Under the demonstration project, the Secretary shall establish appropriate payment rates for such tests.

(2) COVERED COMPLEX DIAGNOSTIC LABORATORY TEST DEFINED.—In this section, the term

1 ''complex diagnostic laboratory test'' means a diag-
2 nostic laboratory test—
3 (A) that is an analysis of gene protein ex-
4 pression, topographic genotyping, or a cancer
5 chemotherapy sensitivity assay;
6 (B) that is determined by the Secretary to
7 be a laboratory test for which there is not an
8 alternative test having equivalent performance
9 characteristics;
10 (C) which is billed using a Health Care
11 Procedure Coding System (HCPCS) code other
12 than a not otherwise classified code under such
13 Coding System;
14 (D) which is approved or cleared by the
15 Food and Drug Administration or is covered
16 under title XVIII of the Social Security Act;
17 and
18 (E) is described in section 1861(s)(3) of
19 the Social Security Act (42 U.S.C.
20 1395x(s)(3)).
21 (3) SEPARATE PAYMENT DEFINED.—In this
22 section, the term ''separate payment'' means direct
23 payment to a laboratory (including a hospital-based
24 or independent laboratory) that performs a complex
25 diagnostic laboratory test with respect to a specimen

1 collected from an individual during a period in which
2 the individual is a patient of a hospital if the test
3 is performed after such period of hospitalization and
4 if separate payment would not otherwise be made
5 under title XVIII of the Social Security Act by rea-
6 son of sections 1862(a)(14) and 1866(a)(1)(H)(i) of
7 the such Act (42 U.S.C. 1395y(a)(14); 42 U.S.C.
8 1395cc(a)(1)(H)(i)).

9 (b) DURATION.—Subject to subsection (c)(2), the
10 Secretary shall conduct the demonstration project under
11 this section for the 2-year period beginning on July 1,
12 2011.

13 (c) PAYMENTS AND LIMITATION.—Payments under
14 the demonstration project under this section shall—

15 (1) be made from the Federal Supplemental
16 Medical Insurance Trust Fund under section 1841
17 of the Social Security Act (42 U.S.C. 1395t); and

18 (2) may not exceed $100,000,000.

19 (d) REPORT.—Not later than 2 years after the com-
20 pletion of the demonstration project under this section, the
21 Secretary shall submit to Congress a report on the project.
22 Such report shall include—

23 (1) an assessment of the impact of the dem-
24 onstration project on access to care, quality of care,
25 health outcomes, and expenditures under title XVIII

of the Social Security Act (including any savings under such title); and

(2) such recommendations as the Secretary determines appropriate.

(e) IMPLEMENTATION FUNDING.—For purposes of administering this section (including preparing and submitting the report under subsection (d)), the Secretary shall provide for the transfer, from the Federal Supplemental Medical Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1395t), to the Centers for Medicare & Medicaid Services Program Management Account, of $5,000,000. Amounts transferred under the preceding sentence shall remain available until expended.

SEC. 3114. IMPROVED ACCESS FOR CERTIFIED NURSE-MIDWIFE SERVICES.

Section 1833(a)(1)(K) of the Social Security Act (42 U.S.C. 1395l(a)(1)(K)) is amended by inserting ''(or 100 percent for services furnished on or after January 1, 2011)'' after ''1992, 65 percent''.

PART II—RURAL PROTECTIONS

SEC. 3121. EXTENSION OF OUTPATIENT HOLD HARMLESS PROVISION.

(a) IN GENERAL.—Section 1833(t)(7)(D)(i) of the Social Security Act (42 U.S.C. 1395l(t)(7)(D)(i)) is amended—

(1) in subclause (II)—

(A) in the first sentence, by striking ''2010''and inserting ''2011''; and

(B) in the second sentence, by striking ''or 2009'' and inserting '', 2009, or 2010''; and

(2) in subclause (III), by striking ''January 1, 2010'' and inserting ''January 1, 2011''.

(b) PERMITTING ALL SOLE COMMUNITY HOSPITALS TO BE ELIGIBLE FOR HOLD HARMLESS.—Section 1833(t)(7)(D)(i)(III) of the Social Security Act (42 U.S.C. 1395l(t)(7)(D)(i)(III)) is amended by adding at the end the following new sentence: ''In the case of covered OPD services furnished on or after January 1, 2010, and before January 1, 2011, the preceding sentence shall be applied without regard to the 100-bed limitation.''.

SEC. 3122. EXTENSION OF MEDICARE REASONABLE COSTS PAYMENTS FOR CERTAIN CLINICAL DIAGNOSTIC LABORATORY TESTS FURNISHED TO HOSPITAL PATIENTS IN CERTAIN RURAL AREAS.

Section 416(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (42 U.S.C. 1395l–4), as amended by section 105 of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395l note) and section 107 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (42 U.S.C. 1395l note), is amended by inserting ''or during the 1-year period beginning on July 1, 2010'' before the period at the end.

SEC. 3123. EXTENSION OF THE RURAL COMMUNITY HOSPITAL DEMONSTRATION PROGRAM.

(a) ONE-YEAR EXTENSION.—Section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2272) is amended by adding at the end the following new subsection:

''(g) ONE-YEAR EXTENSION OF DEMONSTRATION PROGRAM.—

''(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary shall conduct the demonstration program under this section for an additional 1-year period (in this section re-

ferred to as the '1-year extension period') that begins on the date immediately following the last day of the initial 5-year period under subsection (a)(5).

"(2) EXPANSION OF DEMONSTRATION STATES.—Notwithstanding subsection (a)(2), during the 1-year extension period, the Secretary shall expand the number of States with low population densities determined by the Secretary under such subsection to 20. In determining which States to include in such expansion, the Secretary shall use the same criteria and data that the Secretary used to determine the States under such subsection for purposes of the initial 5-year period.

"(3) INCREASE IN MAXIMUM NUMBER OF HOSPITALS PARTICIPATING IN THE DEMONSTRATION PROGRAM.—Notwithstanding subsection (a)(4), during the 1-year extension period, not more than 30 rural community hospitals may participate in the demonstration program under this section.

"(4) NO AFFECT ON HOSPITALS IN DEMONSTRATION PROGRAM ON DATE OF ENACTMENT.—In the case of a rural community hospital that is participating in the demonstration program under this section as of the last day of the initial 5-year period, the Secretary shall provide for the continued

1 participation of such rural community hospital in
2 the demonstration program during the 1-year exten-
3 sion period unless the rural community hospital
4 makes an election, in such form and manner as the
5 Secretary may specify, to discontinue such participa-
6 tion.''.

7 (b) CONFORMING AMENDMENTS.—Subsection (a)(5)
8 of section 410A of the Medicare Prescription Drug, Im-
9 provement, and Modernization Act of 2003 (Public Law
10 108–173; 117 Stat. 2272) is amended by inserting ''(in
11 this section referred to as the 'initial 5-year period') and,
12 as provided in subsection (g), for the 1-year extension pe-
13 riod'' after ''5-year period''.

14 (c) TECHNICAL AMENDMENTS.—

15 (1) Subsection (b) of section 410A of the Medi-
16 care Prescription Drug, Improvement, and Mod-
17 ernization Act of 2003 (Public Law 108–173; 117
18 Stat. 2272) is amended—

19 (A) in paragraph (1)(B)(ii), by striking
20 ''2)'' and inserting ''2))''; and

21 (B) in paragraph (2), by inserting ''cost''
22 before ''reporting period'' the first place such
23 term appears in each of subparagraphs (A) and
24 (B).

(2) Subsection (f)(1) of section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2272) is amended—

(A) in subparagraph (A)(ii), by striking ''paragraph (2)'' and inserting ''subparagraph (B)''; and

(B) in subparagraph (B), by striking ''paragraph (1)(B)'' and inserting ''subparagraph (A)(ii)''.

SEC. 3124. EXTENSION OF THE MEDICARE-DEPENDENT HOSPITAL (MDH) PROGRAM.

(a) EXTENSION OF PAYMENT METHODOLOGY.—Section 1886(d)(5)(G) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(G)) is amended—

(1) in clause (i), by striking ''October 1, 2011'' and inserting ''October 1, 2012''; and

(2) in clause (ii)(II), by striking ''October 1, 2011'' and inserting ''October 1, 2012''.

(b) CONFORMING AMENDMENTS.—

(1) EXTENSION OF TARGET AMOUNT.—Section 1886(b)(3)(D) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(D)) is amended—

(A) in the matter preceding clause (i), by striking ''October 1, 2011'' and inserting ''October 1, 2012''; and

(B) in clause (iv), by striking ''through fiscal year 2011'' and inserting ''through fiscal year 2012''.

(2) PERMITTING HOSPITALS TO DECLINE RECLASSIFICATION.—Section 13501(e)(2) of the Omnibus Budget Reconciliation Act of 1993 (42 U.S.C. 1395ww note) is amended by striking ''through fiscal year 2011'' and inserting ''through fiscal year 2012''.

SEC. 3125. TEMPORARY IMPROVEMENTS TO THE MEDICARE INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR LOW-VOLUME HOSPITALS.

Section 1886(d)(12) of the Social Security Act (42 U.S.C. 1395ww(d)(12)) is amended—

(1) in subparagraph (A), by inserting ''or (D)'' after ''subparagraph (B)'';

(2) in subparagraph (B), in the matter preceding clause (i), by striking ''The Secretary'' and inserting ''For discharges occurring in fiscal years 2005 through 2010 and for discharges occurring in fiscal year 2013 and subsequent fiscal years, the Secretary'';

(3) in subparagraph (C)(i)—

(A) by inserting ''(or, with respect to fiscal years 2011 and 2012, 15 road miles)'' after ''25 road miles''; and

(B) by inserting ''(or, with respect to fiscal years 2011 and 2012, 1,500 discharges of individuals entitled to, or enrolled for, benefits under part A)'' after ''800 discharges''; and

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

''(D) TEMPORARY APPLICABLE PERCENTAGE INCREASE.—For discharges occurring in fiscal years 2011 and 2012, the Secretary shall determine an applicable percentage increase for purposes of subparagraph (A) using a continuous linear sliding scale ranging from 25 percent for low-volume hospitals with 200 or fewer discharges of individuals entitled to, or enrolled for, benefits under part A in the fiscal year to 0 percent for low-volume hospitals with greater than 1,500 discharges of such individuals in the fiscal year.''.

SEC. 3126. IMPROVEMENTS TO THE DEMONSTRATION PROJECT ON COMMUNITY HEALTH INTEGRATION MODELS IN CERTAIN RURAL COUNTIES.

(a) REMOVAL OF LIMITATION ON NUMBER OF ELIGIBLE COUNTIES SELECTED.—Subsection (d)(3) of section 123 of the Medicare Improvements for Patients and Providers Act of 2008 (42 U.S.C. 1395i–4 note) is amended by striking ''not more than 6''.

(b) REMOVAL OF REFERENCES TO RURAL HEALTH CLINIC SERVICES AND INCLUSION OF PHYSICIANS' SERVICES IN SCOPE OF DEMONSTRATION PROJECT.—Such section 123 is amended—

(1) in subsection (d)(4)(B)(i)(3), by striking subclause (III); and

(2) in subsection (j)—

(A) in paragraph (8), by striking subparagraph (B) and inserting the following:

''(B) Physicians' services (as defined in section 1861(q) of the Social Security Act (42 U.S.C. 1395x(q)).'';

(B) by striking paragraph (9); and

(C) by redesignating paragraph (10) as paragraph (9).

SEC. 3127. MEDPAC STUDY ON ADEQUACY OF MEDICARE PAYMENTS FOR HEALTH CARE PROVIDERS SERVING IN RURAL AREAS.

(a) STUDY.—The Medicare Payment Advisory Commission shall conduct a study on the adequacy of payments for items and services furnished by providers of services and suppliers in rural areas under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.). Such study shall include an analysis of—

(1) any adjustments in payments to providers of services and suppliers that furnish items and services in rural areas;

(2) access by Medicare beneficiaries to items and services in rural areas;

(3) the adequacy of payments to providers of services and suppliers that furnish items and services in rural areas; and

(4) the quality of care furnished in rural areas.

(b) REPORT.—Not later than January 1, 2011, the Medicare Payment Advisory Commission shall submit to Congress a report containing the results of the study conducted under subsection (a). Such report shall include recommendations on appropriate modifications to any adjustments in payments to providers of services and suppliers that furnish items and services in rural areas, together

with recommendations for such legislation and administrative action as the Medicare Payment Advisory Commission determines appropriate.

SEC. 3128. TECHNICAL CORRECTION RELATED TO CRITICAL ACCESS HOSPITAL SERVICES.

(a) IN GENERAL.—Subsections (g)(2)(A) and (l)(8) of section 1834 of the Social Security Act (42 U.S.C. 1395m) are each amended by inserting ''101 percent of'' before ''the reasonable costs''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect as if included in the enactment of section 405(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2266).

SEC. 3129. EXTENSION OF AND REVISIONS TO MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM.

(a) AUTHORIZATION.—Section 1820(j) of the Social Security Act (42 U.S.C. 1395i–4(j)) is amended—

(1) by striking ''2010, and for'' and inserting ''2010, for''; and

(2) by inserting ''and for making grants to all States under subsection (g), such sums as may be necessary in each of fiscal years 2011 and 2012, to remain available until expended'' before the period at the end.

(b) USE OF FUNDS.—Section 1820(g)(3) of the Social Security Act (42 U.S.C. 1395i–4(g)(3)) is amended—

(1) in subparagraph (A), by inserting ''and to assist such hospitals in participating in delivery system reforms under the provisions of and amendments made by the Patient Protection and Affordable Care Act, such as value-based purchasing programs, accountable care organizations under section 1899, the National pilot program on payment bundling under section 1866D, and other delivery system reform programs determined appropriate by the Secretary'' before the period at the end; and

(2) in subparagraph (E)—

(A) by striking '', and to offset'' and inserting '', to offset''; and

(B) by inserting ''and to participate in delivery system reforms under the provisions of and amendments made by the Patient Protection and Affordable Care Act, such as value-based purchasing programs, accountable care organizations under section 1899, the National pilot program on payment bundling under section 1866D, and other delivery system reform programs determined appropriate by the Secretary'' before the period at the end.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to grants made on or after January 1, 2010.

PART III—IMPROVING PAYMENT ACCURACY

SEC. 3131. PAYMENT ADJUSTMENTS FOR HOME HEALTH CARE.

(a) REBASING HOME HEALTH PROSPECTIVE PAYMENT AMOUNT.—

(1) IN GENERAL.—Section 1895(b)(3)(A) of the Social Security Act (42 U.S.C. 1395fff(b)(3)(A)) is amended—

(A) in clause (i)(III), by striking ''For periods'' and inserting ''Subject to clause (iii), for periods''; and

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

''(iii) ADJUSTMENT FOR 2013 AND SUBSEQUENT YEARS.—

''(I) IN GENERAL.—Subject to subclause (II), for 2013 and subsequent years, the amount (or amounts) that would otherwise be applicable under clause (i)(III) shall be adjusted by a percentage determined appropriate by the Secretary to reflect such

1 factors as changes in the number of
2 visits in an episode, the mix of serv-
3 ices in an episode, the level of inten-
4 sity of services in an episode, the av-
5 erage cost of providing care per epi-
6 sode, and other factors that the Sec-
7 retary considers to be relevant. In
8 conducting the analysis under the pre-
9 ceding sentence, the Secretary may
10 consider differences between hospital-
11 based and freestanding agencies, be-
12 tween for-profit and nonprofit agen-
13 cies, and between the resource costs of
14 urban and rural agencies. Such ad-
15 justment shall be made before the up-
16 date under subparagraph (B) is ap-
17 plied for the year.
18 ''(II) TRANSITION.—The Sec-
19 retary shall provide for a 4-year
20 phase-in (in equal increments) of the
21 adjustment under subclause (I), with
22 such adjustment being fully imple-
23 mented for 2016. During each year of
24 such phase-in, the amount of any ad-
25 justment under subclause (I) for the

year may not exceed 3.5 percent of the amount (or amounts) applicable under clause (i)(III) as of the date of enactment of the Patient Protection and Affordable Care Act.''.

(2) MEDPAC STUDY AND REPORT.—

(A) STUDY.—The Medicare Payment Advisory Commission shall conduct a study on the implementation of the amendments made by paragraph (1). Such study shall include an analysis of the impact of such amendments on—

(i) access to care;

(ii) quality outcomes;

(iii) the number of home health agencies; and

(iv) rural agencies, urban agencies, for-profit agencies, and nonprofit agencies.

(B) REPORT.—Not later than January 1, 2015, the Medicare Payment Advisory Commission shall submit to Congress a report on the study conducted under subparagraph (A), together with recommendations for such legislation and administrative action as the Commission determines appropriate.

(b) PROGRAM-SPECIFIC OUTLIER CAP.—Section 1895(b) of the Social Security Act (42 U.S.C. 1395fff(b)) is amended—

(1) in paragraph (3)(C), by striking ''the aggregate'' and all that follows through the period at the end and inserting ''5 percent of the total payments estimated to be made based on the prospective payment system under this subsection for the period.''; and

(2) in paragraph (5)—

(A) by striking ''OUTLIERS.—The Secretary'' and inserting the following: ''OUTLIERS.—

''(A) IN GENERAL.—Subject to subparagraph (B), the Secretary'';

(B) in subparagraph (A), as added by subparagraph (A), by striking ''5 percent'' and inserting ''2.5 percent''; and

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

''(B) PROGRAM SPECIFIC OUTLIER CAP.—The estimated total amount of additional payments or payment adjustments made under subparagraph (A) with respect to a home health agency for a year (beginning with 2011) may

not exceed an amount equal to 10 percent of the estimated total amount of payments made under this section (without regard to this paragraph) with respect to the home health agency for the year.''.

(c) APPLICATION OF THE MEDICARE RURAL HOME HEALTH ADD-ON POLICY.—Section 421 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2283), as amended by section 5201(b) of the Deficit Reduction Act of 2005 (Public Law 109–171; 120 Stat. 46), is amended—

(1) in the section heading, by striking ''**ONE-YEAR**'' and inserting ''**TEMPORARY**''; and

(2) in subsection (a)—

(A) by striking '', and episodes'' and inserting '', episodes'';

(B) by inserting ''and episodes and visits ending on or after April 1, 2010, and before January 1, 2016,'' after ''January 1, 2007,''; and

(C) by inserting ''(or, in the case of episodes and visits ending on or after April 1, 2010, and before January 1, 2016, 3 percent)'' before the period at the end.

1 (d) STUDY AND REPORT ON THE DEVELOPMENT OF
2 HOME HEALTH PAYMENT REFORMS IN ORDER TO EN-
3 SURE ACCESS TO CARE AND QUALITY SERVICES.—
4 (1) IN GENERAL.—The Secretary of Health and
5 Human Services (in this section referred to as the
6 ''Secretary'') shall conduct a study to evaluate the
7 costs and quality of care among efficient home
8 health agencies relative to other such agencies in
9 providing ongoing access to care and in treating
10 Medicare beneficiaries with varying severity levels of
11 illness. Such study shall include an analysis of the
12 following:
13 (A) Methods to revise the home health pro-
14 spective payment system under section 1895 of
15 the Social Security Act (42 U.S.C. 1395fff) to
16 more accurately account for the costs related to
17 patient severity of illness or to improving bene-
18 ficiary access to care, including—
19 (i) payment adjustments for services
20 that may be under- or over-valued;
21 (ii) necessary changes to reflect the
22 resource use relative to providing home
23 health services to low-income Medicare
24 beneficiaries or Medicare beneficiaries liv-
25 ing in medically underserved areas;

(iii) ways the outlier payment may be improved to more accurately reflect the cost of treating Medicare beneficiaries with high severity levels of illness;

(iv) the role of quality of care incentives and penalties in driving provider and patient behavior;

(v) improvements in the application of a wage index; and

(vi) other areas determined appropriate by the Secretary.

(B) The validity and reliability of responses on the OASIS instrument with particular emphasis on questions that relate to higher payment under the home health prospective payment system and higher outcome scores under Home Care Compare.

(C) Additional research or payment revisions under the home health prospective payment system that may be necessary to set the payment rates for home health services based on costs of high-quality and efficient home health agencies or to improve Medicare beneficiary access to care.

1 (D) A timetable for implementation of any
2 appropriate changes based on the analysis of
3 the matters described in subparagraphs (A),
4 (B), and (C).
5 (E) Other areas determined appropriate by
6 the Secretary.
7 (2) CONSIDERATIONS.—In conducting the study
8 under paragraph (1), the Secretary shall consider
9 whether certain factors should be used to measure
10 patient severity of illness and access to care, such
11 as—
12 (A) population density and relative patient
13 access to care;
14 (B) variations in service costs for providing
15 care to individuals who are dually eligible under
16 the Medicare and Medicaid programs;
17 (C) the presence of severe or chronic dis-
18 eases, as evidenced by multiple, discontinuous
19 home health episodes;
20 (D) poverty status, as evidenced by the re-
21 ceipt of Supplemental Security Income under
22 title XVI of the Social Security Act;
23 (E) the absence of caregivers;
24 (F) language barriers;
25 (G) atypical transportation costs;

(H) security costs; and

(I) other factors determined appropriate by the Secretary.

(3) REPORT.—Not later than March 1, 2011, the Secretary shall submit to Congress a report on the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

(4) CONSULTATIONS.—In conducting the study under paragraph (1) and preparing the report under paragraph (3), the Secretary shall consult with—

(A) stakeholders representing home health agencies;

(B) groups representing Medicare beneficiaries;

(C) the Medicare Payment Advisory Commission;

(D) the Inspector General of the Department of Health and Human Services; and

(E) the Comptroller General of the United States.

SEC. 3132. HOSPICE REFORM.

(a) HOSPICE CARE PAYMENT REFORMS.—

1 (1) IN GENERAL.—Section 1814(i) of the Social
2 Security Act (42 U.S.C. 1395f(i)), as amended by
3 section 3004(c), is amended—
4 (A) by redesignating paragraph (6) as
5 paragraph (7); and
6 (B) by inserting after paragraph (5) the
7 following new paragraph:
8 ''(6)(A) The Secretary shall collect additional
9 data and information as the Secretary determines
10 appropriate to revise payments for hospice care
11 under this subsection pursuant to subparagraph (D)
12 and for other purposes as determined appropriate by
13 the Secretary. The Secretary shall begin to collect
14 such data by not later than January 1, 2011.
15 ''(B) The additional data and information to be
16 collected under subparagraph (A) may include data
17 and information on—
18 ''(i) charges and payments;
19 ''(ii) the number of days of hospice care
20 which are attributable to individuals who are
21 entitled to, or enrolled for, benefits under part
22 A; and
23 ''(iii) with respect to each type of service
24 included in hospice care—

1 "(I) the number of days of hospice
2 care attributable to the type of service;
3 "(II) the cost of the type of service;
4 and
5 "(III) the amount of payment for the
6 type of service;
7 "(iv) charitable contributions and other
8 revenue of the hospice program;
9 "(v) the number of hospice visits;
10 "(vi) the type of practitioner providing the
11 visit; and
12 "(vii) the length of the visit and other
13 basic information with respect to the visit.
14 "(C) The Secretary may collect the additional
15 data and information under subparagraph (A) on
16 cost reports, claims, or other mechanisms as the
17 Secretary determines to be appropriate.
18 "(D)(i) Notwithstanding the preceding para-
19 graphs of this subsection, not earlier than October
20 1, 2013, the Secretary shall, by regulation, imple-
21 ment revisions to the methodology for determining
22 the payment rates for routine home care and other
23 services included in hospice care under this part, as
24 the Secretary determines to be appropriate. Such re-
25 visions may be based on an analysis of data and in-

1 formation collected under subparagraph (A). Such
2 revisions may include adjustments to per diem pay-
3 ments that reflect changes in resource intensity in
4 providing such care and services during the course
5 of the entire episode of hospice care.

6 ''(ii) Revisions in payment implemented pursu-
7 ant to clause (i) shall result in the same estimated
8 amount of aggregate expenditures under this title
9 for hospice care furnished in the fiscal year in which
10 such revisions in payment are implemented as would
11 have been made under this title for such care in
12 such fiscal year if such revisions had not been imple-
13 mented.

14 ''(E) The Secretary shall consult with hospice
15 programs and the Medicare Payment Advisory Com-
16 mission regarding the additional data and informa-
17 tion to be collected under subparagraph (A) and the
18 payment revisions under subparagraph (D).''.

19 (2) CONFORMING AMENDMENTS.—Section
20 1814(i)(1)(C) of the Social Security Act (42 U.S.C.
21 1395f(i)(1)(C)) is amended—

22 (A) in clause (ii)—

23 (i) in the matter preceding subclause
24 (I), by inserting ''(before the first fiscal
25 year in which the payment revisions de-

1 scribed in paragraph (6)(D) are imple-
2 mented)'' after ''subsequent fiscal year'';
3 and
4 (ii) in subclause (VII), by inserting
5 ''(before the first fiscal year in which the
6 payment revisions described in paragraph
7 (6)(D) are implemented), subject to clause
8 (iv),'' after ''subsequent fiscal year''; and
9 (B) by adding at the end the following new
10 clause:
11 ''(iii) With respect to routine home
12 care and other services included in hospice
13 care furnished during fiscal years subse-
14 quent to the first fiscal year in which pay-
15 ment revisions described in paragraph
16 (6)(D) are implemented, the payment rates
17 for such care and services shall be the pay-
18 ment rates in effect under this clause dur-
19 ing the preceding fiscal year increased by,
20 subject to clause (iv), the market basket
21 percentage increase (as defined in section
22 1886(b)(3)(B)(iii)) for the fiscal year.''.
23 (b) ADOPTION OF MEDPAC HOSPICE PROGRAM ELI-
24 GIBILITY RECERTIFICATION RECOMMENDATIONS.—Sec-

1 tion 1814(a)(7) of the Social Security Act (42 U.S.C.
2 1395f(a)(7)) is amended—
3 (1) in subparagraph (B), by striking ''and'' at
4 the end; and
5 (2) by adding at the end the following new sub-
6 paragraph:
7 ''(D) on and after January 1, 2011—
8 ''(i) a hospice physician or nurse prac-
9 titioner has a face-to-face encounter with
10 the individual to determine continued eligi-
11 bility of the individual for hospice care
12 prior to the 180th-day recertification and
13 each subsequent recertification under sub-
14 paragraph (A)(ii) and attests that such
15 visit took place (in accordance with proce-
16 dures established by the Secretary); and
17 ''(ii) in the case of hospice care pro-
18 vided an individual for more than 180 days
19 by a hospice program for which the num-
20 ber of such cases for such program com-
21 prises more than a percent (specified by
22 the Secretary) of the total number of such
23 cases for all programs under this title, the
24 hospice care provided to such individual is
25 medically reviewed (in accordance with

procedures established by the Secretary); and''.

SEC. 3133. IMPROVEMENT TO MEDICARE DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS.

Section 1886 of the Social Security Act (42 U.S.C. 1395ww), as amended by sections 3001, 3008, and 3025, is amended—

(1) in subsection (d)(5)(F)(i), by striking ''For'' and inserting ''Subject to subsection (r), for''; and

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

''(r) ADJUSTMENTS TO MEDICARE DSH PAYMENTS.—

''(1) EMPIRICALLY JUSTIFIED DSH PAYMENTS.—For fiscal year 2015 and each subsequent fiscal year, instead of the amount of disproportionate share hospital payment that would otherwise be made under subsection (d)(5)(F) to a subsection (d) hospital for the fiscal year, the Secretary shall pay to the subsection (d) hospital 25 percent of such amount (which represents the empirically justified amount for such payment, as determined by the Medicare Payment Advisory Commission in its March 2007 Report to the Congress).

"(2) ADDITIONAL PAYMENT.—In addition to the payment made to a subsection (d) hospital under paragraph (1), for fiscal year 2015 and each subsequent fiscal year, the Secretary shall pay to such subsection (d) hospitals an additional amount equal to the product of the following factors:

"(A) FACTOR ONE.—A factor equal to the difference between—

"(i) the aggregate amount of payments that would be made to subsection (d) hospitals under subsection (d)(5)(F) if this subsection did not apply for such fiscal year (as estimated by the Secretary); and

"(ii) the aggregate amount of payments that are made to subsection (d) hospitals under paragraph (1) for such fiscal year (as so estimated).

"(B) FACTOR TWO.—

"(i) FISCAL YEARS 2015, 2016, AND 2017.—For each of fiscal years 2015, 2016, and 2017, a factor equal to 1 minus the percent change (divided by 100) in the percent of individuals under the age of 65 who

are uninsured, as determined by comparing the percent of such individuals—

"(I) who are uninsured in 2012, the last year before coverage expansion under the Patient Protection and Affordable Care Act (as calculated by the Secretary based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on such Act that, if determined in the affirmative, would clear such Act for enrollment); and

"(II) who are uninsured in the most recent period for which data is available (as so calculated).

"(ii) 2018 AND SUBSEQUENT YEARS.—For fiscal year 2018 and each subsequent fiscal year, a factor equal to 1 minus the percent change (divided by 100) in the percent of individuals who are uninsured, as determined by comparing the percent of individuals—

"(I) who are uninsured in 2012 (as estimated by the Secretary, based

on data from the Census Bureau or other sources the Secretary determines appropriate, and certified by the Chief Actuary of the Centers for Medicare & Medicaid Services); and

"(II) who are uninsured in the most recent period for which data is available (as so estimated and certified).

"(C) FACTOR THREE.—A factor equal to the percent, for each subsection (d) hospital, that represents the quotient of—

"(i) the amount of uncompensated care for such hospital for a period selected by the Secretary (as estimated by the Secretary, based on appropriate data (including, in the case where the Secretary determines that alternative data is available which is a better proxy for the costs of subsection (d) hospitals for treating the uninsured, the use of such alternative data)); and

"(ii) the aggregate amount of uncompensated care for all subsection (d) hospitals that receive a payment under this

subsection for such period (as so estimated, based on such data).

"(3) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the following:

"(A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).

"(B) Any period selected by the Secretary for such purposes.".

SEC. 3134. MISVALUED CODES UNDER THE PHYSICIAN FEE SCHEDULE.

(a) IN GENERAL.—Section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)) is amended by adding at the end the following new subparagraphs:

"(K) POTENTIALLY MISVALUED CODES.—

"(i) IN GENERAL.—The Secretary shall—

"(I) periodically identify services as being potentially misvalued using criteria specified in clause (ii); and

"(II) review and make appropriate adjustments to the relative values established under this paragraph

1 for services identified as being poten-
2 tially misvalued under subclause (I).
3 "(ii) IDENTIFICATION OF POTEN-
4 TIALLY MISVALUED CODES.—For purposes
5 of identifying potentially misvalued services
6 pursuant to clause (i)(I), the Secretary
7 shall examine (as the Secretary determines
8 to be appropriate) codes (and families of
9 codes as appropriate) for which there has
10 been the fastest growth; codes (and fami-
11 lies of codes as appropriate) that have ex-
12 perienced substantial changes in practice
13 expenses; codes for new technologies or
14 services within an appropriate period (such
15 as 3 years) after the relative values are ini-
16 tially established for such codes; multiple
17 codes that are frequently billed in conjunc-
18 tion with furnishing a single service; codes
19 with low relative values, particularly those
20 that are often billed multiple times for a
21 single treatment; codes which have not
22 been subject to review since the implemen-
23 tation of the RBRVS (the so-called 'Har-
24 vard-valued codes'); and such other codes

1 determined to be appropriate by the Sec-
2 retary.
3 ''(iii) REVIEW AND ADJUSTMENTS.—
4 ''(I) The Secretary may use ex-
5 isting processes to receive rec-
6 ommendations on the review and ap-
7 propriate adjustment of potentially
8 misvalued services described in clause
9 (i)(II).
10 ''(II) The Secretary may conduct
11 surveys, other data collection activi-
12 ties, studies, or other analyses as the
13 Secretary determines to be appro-
14 priate to facilitate the review and ap-
15 propriate adjustment described in
16 clause (i)(II).
17 ''(III) The Secretary may use
18 analytic contractors to identify and
19 analyze services identified under
20 clause (i)(I), conduct surveys or col-
21 lect data, and make recommendations
22 on the review and appropriate adjust-
23 ment of services described in clause
24 (i)(II).

"(IV) The Secretary may coordinate the review and appropriate adjustment described in clause (i)(II) with the periodic review described in subparagraph (B).

"(V) As part of the review and adjustment described in clause (i)(II), including with respect to codes with low relative values described in clause (ii), the Secretary may make appropriate coding revisions (including using existing processes for consideration of coding changes) which may include consolidation of individual services into bundled codes for payment under the fee schedule under subsection (b).

"(VI) The provisions of subparagraph (B)(ii)(II) shall apply to adjustments to relative value units made pursuant to this subparagraph in the same manner as such provisions apply to adjustments under subparagraph (B)(ii)(II).

"(L) VALIDATING RELATIVE VALUE UNITS.—

"(i) IN GENERAL.—The Secretary shall establish a process to validate relative value units under the fee schedule under subsection (b).

"(ii) COMPONENTS AND ELEMENTS OF WORK.—The process described in clause (i) may include validation of work elements (such as time, mental effort and professional judgment, technical skill and physical effort, and stress due to risk) involved with furnishing a service and may include validation of the pre-, post-, and intra-service components of work.

"(iii) SCOPE OF CODES.—The validation of work relative value units shall include a sampling of codes for services that is the same as the codes listed under subparagraph (K)(ii).

"(iv) METHODS.—The Secretary may conduct the validation under this subparagraph using methods described in subclauses (I) through (V) of subparagraph

(K)(iii) as the Secretary determines to be appropriate.

"(v) ADJUSTMENTS.—The Secretary shall make appropriate adjustments to the work relative value units under the fee schedule under subsection (b). The provisions of subparagraph (B)(ii)(II) shall apply to adjustments to relative value units made pursuant to this subparagraph in the same manner as such provisions apply to adjustments under subparagraph (B)(ii)(II).".

(b) IMPLEMENTATION.—

(1) ADMINISTRATION.—

(A) Chapter 35 of title 44, United States Code and the provisions of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to this section or the amendment made by this section.

(B) Notwithstanding any other provision of law, the Secretary may implement subparagraphs (K) and (L) of 1848(c)(2) of the Social Security Act, as added by subsection (a), by program instruction or otherwise.

(C) Section 4505(d) of the Balanced Budget Act of 1997 is repealed.

(D) Except for provisions related to confidentiality of information, the provisions of the Federal Acquisition Regulation shall not apply to this section or the amendment made by this section.

(2) FOCUSING CMS RESOURCES ON POTENTIALLY OVERVALUED CODES.—Section 1868(a) of the Social Security Act (42 U.S.C. 1395ee(a)) is repealed.

SEC. 3135. MODIFICATION OF EQUIPMENT UTILIZATION FACTOR FOR ADVANCED IMAGING SERVICES.

(a) ADJUSTMENT IN PRACTICE EXPENSE TO REFLECT HIGHER PRESUMED UTILIZATION.—Section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended—

(1) in subsection (b)(4)—

(A) in subparagraph (B), by striking ''subparagraph (A)'' and inserting ''this paragraph''; and

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

''(C) ADJUSTMENT IN PRACTICE EXPENSE TO REFLECT HIGHER PRESUMED UTILIZA-

TION.—Consistent with the methodology for computing the number of practice expense relative value units under subsection (c)(2)(C)(ii) with respect to advanced diagnostic imaging services (as defined in section 1834(e)(1)(B)) furnished on or after January 1, 2010, the Secretary shall adjust such number of units so it reflects—

"(i) in the case of services furnished on or after January 1, 2010, and before January 1, 2013, a 65 percent (rather than 50 percent) presumed rate of utilization of imaging equipment;

"(ii) in the case of services furnished on or after January 1, 2013, and before January 1, 2014, a 70 percent (rather than 50 percent) presumed rate of utilization of imaging equipment; and

"(iii) in the case of services furnished on or after January 1, 2014, a 75 percent (rather than 50 percent) presumed rate of utilization of imaging equipment."; and

(2) in subsection (c)(2)(B)(v), by adding at the end the following new subclauses:

"(III) CHANGE IN PRESUMED UTILIZATION LEVEL OF CERTAIN ADVANCED DIAGNOSTIC IMAGING SERVICES FOR 2010 THROUGH 2012.—Effective for fee schedules established beginning with 2010 and ending with 2012, reduced expenditures attributable to the presumed rate of utilization of imaging equipment of 65 percent under subsection (b)(4)(C)(i) instead of a presumed rate of utilization of such equipment of 50 percent.

"(IV) CHANGE IN PRESUMED UTILIZATION LEVEL OF CERTAIN ADVANCED DIAGNOSTIC IMAGING SERVICES FOR 2013.—Effective for fee schedules established for 2013, reduced expenditures attributable to the presumed rate of utilization of imaging equipment of 70 percent under subsection (b)(4)(C)(ii) instead of a presumed rate of utilization of such equipment of 50 percent.

"(V) CHANGE IN PRESUMED UTILIZATION LEVEL OF CERTAIN AD-

VANCED DIAGNOSTIC IMAGING SERVICES FOR 2014 AND SUBSEQUENT YEARS.—Effective for fee schedules established beginning with 2014, reduced expenditures attributable to the presumed rate of utilization of imaging equipment of 75 percent under subsection (b)(4)(C)(iii) instead of a presumed rate of utilization of such equipment of 50 percent.''.

(b) ADJUSTMENT IN TECHNICAL COMPONENT ''DISCOUNT'' ON SINGLE-SESSION IMAGING TO CONSECUTIVE BODY PARTS.—Section 1848 of the Social Security Act (42 U.S.C. 1395w–4), as amended by subsection (a), is amended—

(1) in subsection (b)(4), by adding at the end the following new subparagraph:

''(D) ADJUSTMENT IN TECHNICAL COMPONENT DISCOUNT ON SINGLE-SESSION IMAGING INVOLVING CONSECUTIVE BODY PARTS.—For services furnished on or after July 1, 2010, the Secretary shall increase the reduction in payments attributable to the multiple procedure payment reduction applicable to the technical component for imaging under the final rule

published by the Secretary in the Federal Register on November 21, 2005 (part 405 of title 42, Code of Federal Regulations) from 25 percent to 50 percent.''; and

(2) in subsection (c)(2)(B)(v), by adding at the end the following new subclause:

''(VI) ADDITIONAL REDUCED PAYMENT FOR MULTIPLE IMAGING PROCEDURES.—Effective for fee schedules established beginning with 2010 (but not applied for services furnished prior to July 1, 2010), reduced expenditures attributable to the increase in the multiple procedure payment reduction from 25 to 50 percent (as described in subsection (b)(4)(D)).''.

(c) ANALYSIS BY THE CHIEF ACTUARY OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES.—Not later than January 1, 2013, the Chief Actuary of the Centers for Medicare & Medicaid Services shall make publicly available an analysis of whether, for the period of 2010 through 2019, the cumulative expenditure reductions under title XVIII of the Social Security Act that are at-

tributable to the adjustments under the amendments made by this section are projected to exceed $3,000,000,000.

SEC. 3136. REVISION OF PAYMENT FOR POWER-DRIVEN WHEELCHAIRS.

(a) IN GENERAL.—Section 1834(a)(7)(A) of the Social Security Act (42 U.S.C. 1395m(a)(7)(A)) is amended—

(1) in clause (i)—

(A) in subclause (II), by inserting ''subclause (III) and'' after ''Subject to''; and

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

''(III) SPECIAL RULE FOR POWER-DRIVEN WHEELCHAIRS.—For purposes of payment for power-driven wheelchairs, subclause (II) shall be applied by substituting '15 percent' and '6 percent' for '10 percent' and '7.5 percent', respectively.''; and

(2) in clause (iii)—

(A) in the heading, by inserting ''COMPLEX, REHABILITATIVE'' before ''POWER-DRIVEN''; and

(B) by inserting ''complex, rehabilitative'' before ''power-driven''.

(b) TECHNICAL AMENDMENT.—Section 1834(a)(7)(C)(ii)(II) of the Social Security Act (42 U.S.C. 1395m(a)(7)(C)(ii)(II)) is amended by striking ''(A)(ii) or''.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—Subject to paragraph (2), the amendments made by subsection (a) shall take effect on January 1, 2011, and shall apply to power-driven wheelchairs furnished on or after such date.

(2) APPLICATION TO COMPETITIVE BIDDING.—The amendments made by subsection (a) shall not apply to payment made for items and services furnished pursuant to contracts entered into under section 1847 of the Social Security Act (42 U.S.C. 1395w–3) prior to January 1, 2011, pursuant to the implementation of subsection (a)(1)(B)(i)(I) of such section 1847.

SEC. 3137. HOSPITAL WAGE INDEX IMPROVEMENT.

(a) EXTENSION OF SECTION 508 HOSPITAL RECLASSIFICATIONS.—

(1) IN GENERAL.—Subsection (a) of section 106 of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395 note), as amended by section 117 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173) and

1 section 124 of the Medicare Improvements for Pa-
2 tients and Providers Act of 2008 (Public Law 110–
3 275), is amended by striking ''September 30, 2009''
4 and inserting ''September 30, 2010''.

5 (2) USE OF PARTICULAR WAGE INDEX IN FIS-
6 CAL YEAR 2010.—For purposes of implementation of
7 the amendment made by this subsection during fis-
8 cal year 2010, the Secretary shall use the hospital
9 wage index that was promulgated by the Secretary
10 in the Federal Register on August 27, 2009 (74
11 Fed. Reg. 43754), and any subsequent corrections.

12 (b) PLAN FOR REFORMING THE MEDICARE HOS-
13 PITAL WAGE INDEX SYSTEM.—

14 (1) IN GENERAL.—Not later than December 31,
15 2011, the Secretary of Health and Human Services
16 (in this section referred to as the ''Secretary'') shall
17 submit to Congress a report that includes a plan to
18 reform the hospital wage index system under section
19 1886 of the Social Security Act.

20 (2) DETAILS.—In developing the plan under
21 paragraph (1), the Secretary shall take into account
22 the goals for reforming such system set forth in the
23 Medicare Payment Advisory Commission June 2007
24 report entitled ''Report to Congress: Promoting
25 Greater Efficiency in Medicare'', including estab-

lishing a new hospital compensation index system that—

(A) uses Bureau of Labor Statistics data, or other data or methodologies, to calculate relative wages for each geographic area involved;

(B) minimizes wage index adjustments between and within metropolitan statistical areas and statewide rural areas;

(C) includes methods to minimize the volatility of wage index adjustments that result from implementation of policy, while maintaining budget neutrality in applying such adjustments;

(D) takes into account the effect that implementation of the system would have on health care providers and on each region of the country;

(E) addresses issues related to occupational mix, such as staffing practices and ratios, and any evidence on the effect on quality of care or patient safety as a result of the implementation of the system; and

(F) provides for a transition.

1 (3) CONSULTATION.—In developing the plan
2 under paragraph (1), the Secretary shall consult
3 with relevant affected parties.
4 (c) USE OF PARTICULAR CRITERIA FOR DETER-
5 MINING RECLASSIFICATIONS.—Notwithstanding any other
6 provision of law, in making decisions on applications for
7 reclassification of a subsection (d) hospital (as defined in
8 paragraph (1)(B) of section 1886(d) of the Social Security
9 Act (42 U.S.C. 1395ww(d)) for the purposes described in
10 paragraph (10)(D)(v) of such section for fiscal year 2011
11 and each subsequent fiscal year (until the first fiscal year
12 beginning on or after the date that is 1 year after the
13 Secretary of Health and Human Services submits the re-
14 port to Congress under subsection (b)), the Geographic
15 Classification Review Board established under paragraph
16 (10) of such section shall use the average hourly wage
17 comparison criteria used in making such decisions as of
18 September 30, 2008. The preceding sentence shall be ef-
19 fected in a budget neutral manner.

20 **SEC. 3138. TREATMENT OF CERTAIN CANCER HOSPITALS.**

21 Section 1833(t) of the Social Security Act (42 U.S.C.
22 1395l(t)) is amended by adding at the end the following
23 new paragraph:
24 "(18) AUTHORIZATION OF ADJUSTMENT FOR
25 CANCER HOSPITALS.—

"(A) STUDY.—The Secretary shall conduct a study to determine if, under the system under this subsection, costs incurred by hospitals described in section 1886(d)(1)(B)(v) with respect to ambulatory payment classification groups exceed those costs incurred by other hospitals furnishing services under this subsection (as determined appropriate by the Secretary). In conducting the study under this subparagraph, the Secretary shall take into consideration the cost of drugs and biologicals incurred by such hospitals.

"(B) AUTHORIZATION OF ADJUSTMENT.—Insofar as the Secretary determines under subparagraph (A) that costs incurred by hospitals described in section 1886(d)(1)(B)(v) exceed those costs incurred by other hospitals furnishing services under this subsection, the Secretary shall provide for an appropriate adjustment under paragraph (2)(E) to reflect those higher costs effective for services furnished on or after January 1, 2011.".

SEC. 3139. PAYMENT FOR BIOSIMILAR BIOLOGICAL PRODUCTS.

(a) IN GENERAL.—Section 1847A of the Social Security Act (42 U.S.C. 1395w–3a) is amended—

(1) in subsection (b)—

(A) in paragraph (1)—

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

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

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

''(C) in the case of a biosimilar biological product (as defined in subsection (c)(6)(H)), the amount determined under paragraph (8).''; and

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

''(8) BIOSIMILAR BIOLOGICAL PRODUCT.—The amount specified in this paragraph for a biosimilar biological product described in paragraph (1)(C) is the sum of—

''(A) the average sales price as determined using the methodology described under paragraph (6) applied to a biosimilar biological

product for all National Drug Codes assigned to such product in the same manner as such paragraph is applied to drugs described in such paragraph; and

"(B) 6 percent of the amount determined under paragraph (4) for the reference biological product (as defined in subsection (c)(6)(I)).";

and

(2) in subsection (c)(6), by adding at the end the following new subparagraph:

"(H) BIOSIMILAR BIOLOGICAL PRODUCT.—The term 'biosimilar biological product' means a biological product approved under an abbreviated application for a license of a biological product that relies in part on data or information in an application for another biological product licensed under section 351 of the Public Health Service Act.

"(I) REFERENCE BIOLOGICAL PRODUCT.—The term 'reference biological product' means the biological product licensed under such section 351 that is referred to in the application described in subparagraph (H) of the biosimilar biological product.".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to payments for biosimilar biological products beginning with the first day of the second calendar quarter after enactment of legislation providing for a biosimilar pathway (as determined by the Secretary).

SEC. 3140. MEDICARE HOSPICE CONCURRENT CARE DEMONSTRATION PROGRAM.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish a Medicare Hospice Concurrent Care demonstration program at participating hospice programs under which Medicare beneficiaries are furnished, during the same period, hospice care and any other items or services covered under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) from funds otherwise paid under such title to such hospice programs.

(2) DURATION.—The demonstration program under this section shall be conducted for a 3-year period.

(3) SITES.—The Secretary shall select not more than 15 hospice programs at which the demonstration program under this section shall be conducted.

1 Such hospice programs shall be located in urban and
2 rural areas.
3 (b) INDEPENDENT EVALUATION AND REPORTS.—
4 (1) INDEPENDENT EVALUATION.—The Sec-
5 retary shall provide for the conduct of an inde-
6 pendent evaluation of the demonstration program
7 under this section. Such independent evaluation
8 shall determine whether the demonstration program
9 has improved patient care, quality of life, and cost-
10 effectiveness for Medicare beneficiaries participating
11 in the demonstration program.
12 (2) REPORTS.—The Secretary shall submit to
13 Congress a report containing the results of the eval-
14 uation conducted under paragraph (1), together with
15 such recommendations as the Secretary determines
16 appropriate.
17 (c) BUDGET NEUTRALITY.—With respect to the 3-
18 year period of the demonstration program under this sec-
19 tion, the Secretary shall ensure that the aggregate expend-
20 itures under title XVIII for such period shall not exceed
21 the aggregate expenditures that would have been expended
22 under such title if the demonstration program under this
23 section had not been implemented.

SEC. 3141. APPLICATION OF BUDGET NEUTRALITY ON A NATIONAL BASIS IN THE CALCULATION OF THE MEDICARE HOSPITAL WAGE INDEX FLOOR.

In the case of discharges occurring on or after October 1, 2010, for purposes of applying section 4410 of the Balanced Budget Act of 1997 (42 U.S.C. 1395ww note) and paragraph (h)(4) of section 412.64 of title 42, Code of Federal Regulations, the Secretary of Health and Human Services shall administer subsection (b) of such section 4410 and paragraph (e) of such section 412.64 in the same manner as the Secretary administered such subsection (b) and paragraph (e) for discharges occurring during fiscal year 2008 (through a uniform, national adjustment to the area wage index).

SEC. 3142. HHS STUDY ON URBAN MEDICARE-DEPENDENT HOSPITALS.

(a) STUDY.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall conduct a study on the need for an additional payment for urban Medicare-dependent hospitals for inpatient hospital services under section 1886 of the Social Security Act (42 U.S.C. 1395ww). Such study shall include an analysis of—

(A) the Medicare inpatient margins of urban Medicare-dependent hospitals, as com-

pared to other hospitals which receive 1 or more additional payments or adjustments under such section (including those payments or adjustments described in paragraph (2)(A)); and

(B) whether payments to medicare-dependent, small rural hospitals under subsection (d)(5)(G) of such section should be applied to urban Medicare-dependent hospitals.

(2) URBAN MEDICARE-DEPENDENT HOSPITAL DEFINED.—For purposes of this section, the term ''urban Medicare-dependent hospital'' means a subsection (d) hospital (as defined in subsection (d)(1)(B) of such section) that—

(A) does not receive any additional payment or adjustment under such section, such as payments for indirect medical education costs under subsection (d)(5)(B) of such section, disproportionate share payments under subsection (d)(5)(A) of such section, payments to a rural referral center under subsection (d)(5)(C) of such section, payments to a critical access hospital under section 1814(l) of such Act (42 U.S.C. 1395f(l)), payments to a sole community hospital under subsection (d)(5)(D) of such section 1886, or payments to a medicare-depend-

ent, small rural hospital under subsection (d)(5)(G) of such section 1886; and

(B) for which more than 60 percent of its inpatient days or discharges during 2 of the 3 most recently audited cost reporting periods for which the Secretary has a settled cost report were attributable to inpatients entitled to benefits under part A of title XVIII of such Act.

(b) REPORT.—Not later than 9 months after the date of enactment of this Act, the Secretary shall submit to Congress a report containing the results of the study conducted under subsection (a), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

Subtitle C—Provisions Relating to Part C

SEC. 3201. MEDICARE ADVANTAGE PAYMENT.

(a) MA BENCHMARK BASED ON PLAN'S COMPETITIVE BIDS.—

(1) IN GENERAL.—Section 1853(j) of the Social Security Act (42 U.S.C. 1395w–23(j)) is amended—

(A) by striking ''AMOUNTS.—For purposes'' and inserting ″AMOUNTS.—

''(1) IN GENERAL.—For purposes'';

(B) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B), respectively, and indenting the subparagraphs appropriately;

(C) in subparagraph (A), as redesignated by subparagraph (B)—

(i) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively, and indenting the clauses appropriately; and

(ii) in clause (i), as redesignated by clause (i), by striking ''an amount equal to'' and all that follows through the end and inserting ''an amount equal to—

''(I) for years before 2007, 1/12 of the annual MA capitation rate under section 1853(c)(1) for the area for the year, adjusted as appropriate for the purpose of risk adjustment;

''(II) for 2007 through 2011, 1/12 of the applicable amount determined under subsection (k)(1) for the area for the year;

''(III) for 2012, the sum of—

''(aa) 2/3 of the quotient of—

"(AA) the applicable amount determined under subsection (k)(1) for the area for the year; and

"(BB) 12; and

"(bb) ⅓ of the MA competitive benchmark amount (determined under paragraph (2)) for the area for the month;

"(IV) for 2013, the sum of—

"(aa) ⅓ of the quotient of—

"(AA) the applicable amount determined under subsection (k)(1) for the area for the year; and

"(BB) 12; and

"(bb) ⅔ of the MA competitive benchmark amount (as so determined) for the area for the month;

"(V) for 2014, the MA competitive benchmark amount for the area for a month in 2013 (as so determined), increased by the national per

capita MA growth percentage, described in subsection (c)(6) for 2014, but not taking into account any adjustment under subparagraph (C) of such subsection for a year before 2004; and

"(VI) for 2015 and each subsequent year, the MA competitive benchmark amount (as so determined) for the area for the month; or";

(iii) in clause (ii), as redesignated by clause (i), by striking "subparagraph (A)" and inserting "clause (i)";

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

"(2) COMPUTATION OF MA COMPETITIVE BENCHMARK AMOUNT.—

"(A) IN GENERAL.—Subject to subparagraph (B) and paragraph (3), for months in each year (beginning with 2012) for each MA payment area the Secretary shall compute an MA competitive benchmark amount equal to the weighted average of the unadjusted MA statutory non-drug monthly bid amount (as defined in section 1854(b)(2)(E)) for each MA plan in

the area, with the weight for each plan being equal to the average number of beneficiaries enrolled under such plan in the reference month (as defined in section 1858(f)(4), except that, in applying such definition for purposes of this paragraph, 'to compute the MA competitive benchmark amount under section 1853(j)(2)' shall be substituted for 'to compute the percentage specified in subparagraph (A) and other relevant percentages under this part').

"(B) WEIGHTING RULES.—

"(i) SINGLE PLAN RULE.—In the case of an MA payment area in which only a single MA plan is being offered, the weight under subparagraph (A) shall be equal to 1.

"(ii) USE OF SIMPLE AVERAGE AMONG MULTIPLE PLANS IF NO PLANS OFFERED IN PREVIOUS YEAR.—In the case of an MA payment area in which no MA plan was offered in the previous year and more than 1 MA plan is offered in the current year, the Secretary shall use a simple average of the unadjusted MA statutory non-drug monthly bid amount (as so defined) for

1 purposes of computing the MA competitive
2 benchmark amount under subparagraph
3 (A).
4 ''(3) CAP ON MA COMPETITIVE BENCHMARK
5 AMOUNT.—In no case shall the MA competitive
6 benchmark amount for an area for a month in a
7 year be greater than the applicable amount that
8 would (but for the application of this subsection) be
9 determined under subsection (k)(1) for the area for
10 the month in the year.''; and
11 (E) in subsection (k)(2)(B)(ii)(III), by
12 striking ''(j)(1)(A)'' and inserting
13 ''(j)(1)(A)(i)''.
14 (2) CONFORMING AMENDMENTS.—
15 (A) Section 1853(k)(2) of the Social Secu-
16 rity Act (42 U.S.C. 1395w–23(k)(2)) is amend-
17 ed—
18 (i) in subparagraph (A), by striking
19 ''through 2010'' and inserting ''and subse-
20 quent years''; and
21 (ii) in subparagraph (C)—
22 (I) in clause (iii), by striking
23 ''and'' at the end;

(II) in clause (iv), by striking the period at the end and inserting "; and"; and

(III) by adding at the end the following new clause:

"(v) for 2011 and subsequent years, 0.00.".

(B) Section 1854(b) of the Social Security Act (42 U.S.C. 1395w–24(b)) is amended—

(i) in paragraph (3)(B)(i), by striking "1853(j)(1)" and inserting "1853(j)(1)(A)"; and

(ii) in paragraph (4)(B)(i), by striking "1853(j)(2)" and inserting "1853(j)(1)(B)".

(C) Section 1858(f) of the Social Security Act (42 U.S.C. 1395w–27(f)) is amended—

(i) in paragraph (1), by striking "1853(j)(2)" and inserting "1853(j)(1)(B)"; and

(ii) in paragraph (3)(A), by striking "1853(j)(1)(A)" and inserting "1853(j)(1)(A)(i)".

(D) Section 1860C–1(d)(1)(A) of the Social Security Act (42 U.S.C. 1395w–

29(d)(1)(A)) is amended by striking "1853(j)(1)(A)" and inserting "1853(j)(1)(A)(i)".

(b) REDUCTION OF NATIONAL PER CAPITA GROWTH PERCENTAGE FOR 2011.—Section 1853(c)(6) of the Social Security Act (42 U.S.C. 1395w–23(c)(6)) is amended—

(1) in clause (v), by striking "and" at the end;

(2) in clause (vi)—

(A) by striking "for a year after 2002" and inserting "for 2003 through 2010"; and

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

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

"(vii) for 2011, 3 percentage points; and

"(viii) for a year after 2011, 0 percentage points.".

(c) ENHANCEMENT OF BENEFICIARY REBATES.—Section 1854(b)(1)(C)(i) of the Social Security Act (42 U.S.C. 1395w–24(b)(1)(C)(i)) is amended by inserting "(or 100 percent in the case of plan years beginning on or after January 1, 2014)" after "75 percent".

(d) BIDDING RULES.—

(1) REQUIREMENTS FOR INFORMATION SUBMITTED.—Section 1854(a)(6)(A) of the Social Security Act (42 U.S.C. 1395w–24(a)(6)(A)) is amended, in the flush matter following clause (v), by adding at the end the following sentence: ''Information to be submitted under this paragraph shall be certified by a qualified member of the American Academy of Actuaries and shall meet actuarial guidelines and rules established by the Secretary under subparagraph (B)(v).''.

(2) ESTABLISHMENT OF ACTUARIAL GUIDELINES.—Section 1854(a)(6)(B) of the Social Security Act (42 U.S.C. 1395w–24(a)(6)(B)) is amended—

(A) in clause (i), by striking ''(iii) and (iv)'' and inserting ''(iii), (iv), and (v)''; and

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

''(v) ESTABLISHMENT OF ACTUARIAL GUIDELINES.—

''(I) IN GENERAL.—In order to establish fair MA competitive benchmarks under section 1853(j)(1)(A)(i), the Secretary, acting through the Chief Actuary of the Centers for

1 Medicare & Medicaid Services (in this
2 clause referred to as the 'Chief Actu-
3 ary'), shall establish—
4 "(aa) actuarial guidelines
5 for the submission of bid infor-
6 mation under this paragraph;
7 and
8 "(bb) bidding rules that are
9 appropriate to ensure accurate
10 bids and fair competition among
11 MA plans.
12 "(II) DENIAL OF BID
13 AMOUNTS.—The Secretary shall deny
14 monthly bid amounts submitted under
15 subparagraph (A) that do not meet
16 the actuarial guidelines and rules es-
17 tablished under subclause (I).
18 "(III) REFUSAL TO ACCEPT CER-
19 TAIN BIDS DUE TO MISREPRESENTA-
20 TIONS AND FAILURES TO ADE-
21 QUATELY MEET REQUIREMENTS.—In
22 the case where the Secretary deter-
23 mines that information submitted by
24 an MA organization under subpara-
25 graph (A) contains consistent mis-

representations and failures to adequately meet requirements of the organization, the Secretary may refuse to accept any additional such bid amounts from the organization for the plan year and the Chief Actuary shall, if the Chief Actuary determines that the actuaries of the organization were complicit in those misrepresentations and failures, report those actuaries to the Actuarial Board for Counseling and Discipline.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to bid amounts submitted on or after January 1, 2012.

(e) MA LOCAL PLAN SERVICE AREAS.—

(1) IN GENERAL.—Section 1853(d) of the Social Security Act (42 U.S.C. 1395w–23(d)) is amended—

(A) in the subsection heading, by striking ''MA REGION'' and inserting ''MA REGION; MA LOCAL PLAN SERVICE AREA'';

(B) in paragraph (1), by striking subparagraph (A) and inserting the following:

''(A) with respect to an MA local plan—

"(i) for years before 2012, an MA local area (as defined in paragraph (2)); and

"(ii) for 2012 and succeeding years, a service area that is an entire urban or rural area, as applicable (as described in paragraph (5)); and"; and

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

"(5) MA LOCAL PLAN SERVICE AREA.—For 2012 and succeeding years, the service area for an MA local plan shall be an entire urban or rural area in each State as follows:

"(A) URBAN AREAS.—

"(i) IN GENERAL.—Subject to clause (ii) and subparagraphs (C) and (D), the service area for an MA local plan in an urban area shall be the Core Based Statistical Area (in this paragraph referred to as a 'CBSA') or, if applicable, a conceptually similar alternative classification, as defined by the Director of the Office of Management and Budget.

"(ii) CBSA COVERING MORE THAN ONE STATE.—In the case of a CBSA (or

alternative classification) that covers more than one State, the Secretary shall divide the CBSA (or alternative classification) into separate service areas with respect to each State covered by the CBSA (or alternative classification).

"(B) RURAL AREAS.—Subject to subparagraphs (C) and (D), the service area for an MA local plan in a rural area shall be a county that does not qualify for inclusion in a CBSA (or alternative classification), as defined by the Director of the Office of Management and Budget.

"(C) REFINEMENTS TO SERVICE AREAS.—For 2015 and succeeding years, in order to reflect actual patterns of health care service utilization, the Secretary may adjust the boundaries of service areas for MA local plans in urban areas and rural areas under subparagraphs (A) and (B), respectively, but may only do so based on recent analyses of actual patterns of care.

"(D) ADDITIONAL AUTHORITY TO MAKE LIMITED EXCEPTIONS TO SERVICE AREA REQUIREMENTS FOR MA LOCAL PLANS.—The Secretary may, in addition to any adjustments

under subparagraph (C), make limited exceptions to service area requirements otherwise applicable under this part for MA local plans that have in effect (as of the date of enactment of the Patient Protection and Affordable Care Act)—

"(i) agreements with another MA organization or MA plan that preclude the offering of benefits throughout an entire service area; or

"(ii) limitations in their structural capacity to support adequate networks throughout an entire service area as a result of the delivery system model of the MA local plan.".

(2) CONFORMING AMENDMENTS.—

(A) IN GENERAL.—

(i) Section 1851(b)(1) of the Social Security Act (42 U.S.C. 1395w–21(b)(1)) is amended by striking subparagraph (C).

(ii) Section 1853(b)(1)(B)(i) of such Act (42 U.S.C. 1395w–23(b)(1)(B)(i))—

(I) in the matter preceding subclause (I), by striking "MA payment

area'' and inserting ''MA local area (as defined in subsection (d)(2))''; and

(II) in subclause (I), by striking ''MA payment area'' and inserting ''MA local area (as so defined)''.

(iii) Section 1853(b)(4) of such Act (42 U.S.C. 1395w–23(b)(4)) is amended by striking ''Medicare Advantage payment area'' and inserting ''MA local area (as so defined)''.

(iv) Section 1853(c)(1) of such Act (42 U.S.C. 1395w–23(c)(1)) is amended—

(I) in the matter preceding subparagraph (A), by striking ''a Medicare Advantage payment area that is''; and

(II) in subparagraph (D)(i), by striking ''MA payment area'' and inserting ''MA local area (as defined in subsection (d)(2))''.

(v) Section 1854 of such Act (42 U.S.C. 1395w–24) is amended by striking subsection (h).

1 (B) EFFECTIVE DATE.—The amendments
2 made by this paragraph shall take effect on
3 January 1, 2012.
4 (f) PERFORMANCE BONUSES.—
5 (1) MA PLANS.—
6 (A) IN GENERAL.—Section 1853 of the So-
7 cial Security Act (42 U.S.C. 1395w–23) is
8 amended by adding at the end the following
9 new subsection:
10 ''(n) PERFORMANCE BONUSES.—
11 ''(1) CARE COORDINATION AND MANAGEMENT
12 PERFORMANCE BONUS.—
13 ''(A) IN GENERAL.—For years beginning
14 with 2014, subject to subparagraph (B), in the
15 case of an MA plan that conducts 1 or more
16 programs described in subparagraph (C) with
17 respect to the year, the Secretary shall, in addi-
18 tion to any other payment provided under this
19 part, make monthly payments, with respect to
20 coverage of an individual under this part, to the
21 MA plan in an amount equal to the product
22 of—
23 ''(i) 0.5 percent of the national
24 monthly per capita cost for expenditures
25 for individuals enrolled under the original

1 medicare fee-for-service program for the
2 year; and
3 "(ii) the total number of programs de-
4 scribed in clauses (i) through (ix) of sub-
5 paragraph (C) that the Secretary deter-
6 mines the plan is conducting for the year
7 under such subparagraph.
8 "(B) LIMITATION.—In no case may the
9 total amount of payment with respect to a year
10 under subparagraph (A) be greater than 2 per-
11 cent of the national monthly per capita cost for
12 expenditures for individuals enrolled under the
13 original medicare fee-for-service program for
14 the year, as determined prior to the application
15 of risk adjustment under paragraph (4).
16 "(C) PROGRAMS DESCRIBED.—The fol-
17 lowing programs are described in this para-
18 graph:
19 "(i) Care management programs
20 that—
21 "(I) target individuals with 1 or
22 more chronic conditions;
23 "(II) identify gaps in care; and
24 "(III) facilitate improved care by
25 using additional resources like nurses,

1 nurse practitioners, and physician as-
2 sistants.
3 "(ii) Programs that focus on patient
4 education and self-management of health
5 conditions, including interventions that—
6 "(I) help manage chronic condi-
7 tions;
8 "(II) reduce declines in health
9 status; and
10 "(III) foster patient and provider
11 collaboration.
12 "(iii) Transitional care interventions
13 that focus on care provided around a hos-
14 pital inpatient episode, including programs
15 that target post-discharge patient care in
16 order to reduce unnecessary health com-
17 plications and readmissions.
18 "(iv) Patient safety programs, includ-
19 ing provisions for hospital-based patient
20 safety programs in contracts that the
21 Medicare Advantage organization offering
22 the MA plan has with hospitals.
23 "(v) Financial policies that promote
24 systematic coordination of care by primary
25 care physicians across the full spectrum of

1 specialties and sites of care, such as med-
2 ical homes, capitation arrangements, or
3 pay-for-performance programs.
4 ''(vi) Programs that address, identify,
5 and ameliorate health care disparities
6 among principal at-risk subpopulations.
7 ''(vii) Medication therapy manage-
8 ment programs that are more extensive
9 than is required under section 1860D–4(c)
10 (as determined by the Secretary).
11 ''(viii) Health information technology
12 programs, including clinical decision sup-
13 port and other tools to facilitate data col-
14 lection and ensure patient-centered, appro-
15 priate care.
16 ''(ix) Such other care management
17 and coordination programs as the Sec-
18 retary determines appropriate.
19 ''(D) CONDUCT OF PROGRAM IN URBAN
20 AND RURAL AREAS.—An MA plan may conduct
21 a program described in subparagraph (C) in a
22 manner appropriate for an urban or rural area,
23 as applicable.
24 ''(E) REPORTING OF DATA.—Each Medi-
25 care Advantage organization shall provide to

the Secretary the information needed to determine whether they are eligible for a care coordination and management performance bonus at a time and in a manner specified by the Secretary.

"(F) PERIODIC AUDITING.—The Secretary shall provide for the annual auditing of programs described in subparagraph (C) for which an MA plan receives a care coordination and management performance bonus under this paragraph. The Comptroller General shall monitor auditing activities conducted under this subparagraph.

"(2) QUALITY PERFORMANCE BONUSES.—

"(A) QUALITY BONUS.—For years beginning with 2014, the Secretary shall, in addition to any other payment provided under this part, make monthly payments, with respect to coverage of an individual under this part, to an MA plan that achieves at least a 3 star rating (or comparable rating) on a rating system described in subparagraph (C) in an amount equal to—

"(i) in the case of a plan that achieves a 3 star rating (or comparable rating) on

1 such system 2 percent of the national
2 monthly per capita cost for expenditures
3 for individuals enrolled under the original
4 medicare fee-for-service program for the
5 year; and
6 "(ii) in the case of a plan that
7 achieves a 4 or 5 star rating (or com-
8 parable rating on such system, 4 percent
9 of such national monthly per capita cost
10 for the year.
11 "(B) IMPROVED QUALITY BONUS.—For
12 years beginning with 2014, in the case of an
13 MA plan that does not receive a quality bonus
14 under subparagraph (A) and is an improved
15 quality MA plan with respect to the year (as
16 identified by the Secretary), the Secretary shall,
17 in addition to any other payment provided
18 under this part, make monthly payments, with
19 respect to coverage of an individual under this
20 part, to the MA plan in an amount equal to 1
21 percent of such national monthly per capita
22 cost for the year.
23 "(C) USE OF RATING SYSTEM.—For pur-
24 poses of subparagraph (A), a rating system de-
25 scribed in this paragraph is—

1 "(i) a rating system that uses up to 5
2 stars to rate clinical quality and enrollee
3 satisfaction and performance at the Medi-
4 care Advantage contract or MA plan level;
5 or
6 "(ii) such other system established by
7 the Secretary that provides for the deter-
8 mination of a comparable quality perform-
9 ance rating to the rating system described
10 in clause (i).
11 "(D) DATA USED IN DETERMINING
12 SCORE.—
13 "(i) IN GENERAL.—The rating of an
14 MA plan under the rating system described
15 in subparagraph (C) with respect to a year
16 shall be based on based on the most recent
17 data available.
18 "(ii) PLANS THAT FAIL TO REPORT
19 DATA.—An MA plan which does not report
20 data that enables the Secretary to rate the
21 plan for purposes of subparagraph (A) or
22 identify the plan for purposes of subpara-
23 graph (B) shall be counted, for purposes of
24 such rating or identification, as having the
25 lowest plan performance rating and the

1 lowest percentage improvement, respec-
2 tively.
3 "(3) QUALITY BONUS FOR NEW AND LOW EN-
4 ROLLMENT MA PLANS.—
5 "(A) NEW MA PLANS.—For years begin-
6 ning with 2014, in the case of an MA plan that
7 first submits a bid under section 1854(a)(1)(A)
8 for 2012 or a subsequent year, only receives en-
9 rollments made during the coverage election pe-
10 riods described in section 1851(e), and is not
11 able to receive a bonus under subparagraph (A)
12 or (B) of paragraph (2) for the year, the Sec-
13 retary shall, in addition to any other payment
14 provided under this part, make monthly pay-
15 ments, with respect to coverage of an individual
16 under this part, to the MA plan in an amount
17 equal to 2 percent of national monthly per cap-
18 ita cost for expenditures for individuals enrolled
19 under the original medicare fee-for-service pro-
20 gram for the year. In its fourth year of oper-
21 ation, the MA plan shall be paid in the same
22 manner as other MA plans with comparable en-
23 rollment.
24 "(B) LOW ENROLLMENT PLANS.—For
25 years beginning with 2014, in the case of an

1 MA plan that has low enrollment (as defined by
2 the Secretary) and would not otherwise be able
3 to receive a bonus under subparagraph (A) or
4 (B) of paragraph (2) or subparagraph (A) of
5 this paragraph for the year (referred to in this
6 subparagraph as a 'low enrollment plan'), the
7 Secretary shall use a regional or local mean of
8 the rating of all MA plans in the region or local
9 area, as determined appropriate by the Sec-
10 retary, on measures used to determine whether
11 MA plans are eligible for a quality or an im-
12 proved quality bonus, as applicable, to deter-
13 mine whether the low enrollment plan is eligible
14 for a bonus under such a subparagraph.

15 "(4) RISK ADJUSTMENT.—The Secretary shall
16 risk adjust a performance bonus under this sub-
17 section in the same manner as the Secretary risk ad-
18 justs beneficiary rebates described in section
19 1854(b)(1)(C).

20 "(5) NOTIFICATION.—The Secretary, in the an-
21 nual announcement required under subsection
22 (b)(1)(B) for 2014 and each succeeding year, shall
23 notify the Medicare Advantage organization of any
24 performance bonus (including a care coordination
25 and management performance bonus under para-

graph (1), a quality performance bonus under paragraph (2), and a quality bonus for new and low enrollment plans under paragraph (3)) that the organization will receive under this subsection with respect to the year. The Secretary shall provide for the publication of the information described in the previous sentence on the Internet website of the Centers for Medicare & Medicaid Services.''

(B) CONFORMING AMENDMENT.—Section 1853(a)(1)(B) of the Social Security Act (42 U.S.C. 1395w–23(a)(1)(B)) is amended—

(i) in clause (i), by inserting ''and any performance bonus under subsection (n)'' before the period at the end; and

(ii) in clause (ii), by striking ''(G)'' and inserting ''(G), plus the amount (if any) of any performance bonus under subsection (n)''.

(2) APPLICATION OF PERFORMANCE BONUSES TO MA REGIONAL PLANS.—Section 1858 of the Social Security Act (42 U.S.C. 1395w–27a) is amended—

(A) in subsection (f)(1), by striking ''subsection (e)'' and inserting ''subsections (e) and (i)''; and

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

"(i) APPLICATION OF PERFORMANCE BONUSES TO MA REGIONAL PLANS.—For years beginning with 2014, the Secretary shall apply the performance bonuses under section 1853(n) (relating to bonuses for care coordination and management, quality performance, and new and low enrollment MA plans) to MA regional plans in a similar manner as such performance bonuses apply to MA plans under such subsection.".

(g) GRANDFATHERING SUPPLEMENTAL BENEFITS FOR CURRENT ENROLLEES AFTER IMPLEMENTATION OF COMPETITIVE BIDDING.—Section 1853 of the Social Security Act (42 U.S.C. 1395w–23), as amended by subsection (f), is amended by adding at the end the following new subsection:

"(o) GRANDFATHERING SUPPLEMENTAL BENEFITS FOR CURRENT ENROLLES AFTER IMPLEMENTATION OF COMPETITIVE BIDDING.—

"(1) IDENTIFICATION OF AREAS.—The Secretary shall identify MA local areas in which, with respect to 2009, average bids submitted by an MA organization under section 1854(a) for MA local plans in the area are not greater than 75 percent of the adjusted average per capita cost for the year in-

volved, determined under section 1876(a)(4), for the area for individuals who are not enrolled in an MA plan under this part for the year, but adjusted to exclude costs attributable to payments under section 1848(o), 1886(n), and 1886(h).

"(2) ELECTION TO PROVIDE REBATES TO GRANDFATHERED ENROLLEES.—

"(A) IN GENERAL.—For years beginning with 2012, each Medicare Advantage organization offering an MA local plan in an area identified by the Secretary under paragraph (1) may elect to provide rebates to grandfathered enrollees under section 1854(b)(1)(C). In the case where an MA organization makes such an election, the monthly per capita dollar amount of such rebates shall not exceed the applicable amount for the year (as defined in subparagraph (B)).

"(B) APPLICABLE AMOUNT.—For purposes of this subsection, the term 'applicable amount' means—

"(i) for 2012, the monthly per capita dollar amount of such rebates provided to enrollees under the MA local plan with respect to 2011; and

"(ii) for a subsequent year, 95 percent of the amount determined under this subparagraph for the preceding year.

"(3) SPECIAL RULES FOR PLANS IN IDENTIFIED AREAS.—Notwithstanding any other provision of this part, the following shall apply with respect to each Medicare Advantage organization offering an MA local plan in an area identified by the Secretary under paragraph (1) that makes an election described in paragraph (2):

"(A) PAYMENTS.—The amount of the monthly payment under this section to the Medicare Advantage organization, with respect to coverage of a grandfathered enrollee under this part in the area for a month, shall be equal to—

"(i) for 2012 and 2013, the sum of—

"(I) the bid amount under section 1854(a) for the MA local plan; and

"(II) the applicable amount (as defined in paragraph (2)(B)) for the MA local plan for the year.

"(ii) for 2014 and subsequent years, the sum of—

"(I) the MA competitive benchmark amount under subsection (j)(1)(A)(i) for the area for the month, adjusted, only to the extent the Secretary determines necessary, to account for induced utilization as a result of rebates provided to grandfathered enrollees (except that such adjustment shall not exceed 0.5 percent of such MA competitive benchmark amount); and

"(II) the applicable amount (as so defined) for the MA local plan for the year.

"(B) REQUIREMENT TO SUBMIT BIDS UNDER COMPETITIVE BIDDING.—The Medicare Advantage organization shall submit a single bid amount under section 1854(a) for the MA local plan. The Medicare Advantage organization shall remove from such bid amount any effects of induced demand for care that may result from the higher rebates available to grandfathered enrollees under this subsection.

"(C) NONAPPLICATION OF BONUS PAYMENTS AND ANY OTHER REBATES.—The Medi-

care Advantage organization offering the MA local plan shall not be eligible for any bonus payment under subsection (n) or any rebate under this part (other than as provided under this subsection) with respect to grandfathered enrollees.

"(D) NONAPPLICATION OF UNIFORM BID AND PREMIUM AMOUNTS TO GRANDFATHERED ENROLLEES.—Section 1854(c) shall not apply with respect to the MA local plan.

"(E) NONAPPLICATION OF LIMITATION ON APPLICATION OF PLAN REBATES TOWARD PAYMENT OF PART B PREMIUM.—Notwithstanding clause (iii) of section 1854(b)(1)(C), in the case of a grandfathered enrollee, a rebate under such section may be used for the purpose described in clause (ii)(III) of such section.

"(F) RISK ADJUSTMENT.—The Secretary shall risk adjust rebates to grandfathered enrollees under this subsection in the same manner as the Secretary risk adjusts beneficiary rebates described in section 1854(b)(1)(C).

"(4) DEFINITION OF GRANDFATHERED ENROLLEE.—In this subsection, the term 'grandfathered enrollee' means an individual who is en-

1 rolled (effective as of the date of enactment of this
2 subsection) in an MA local plan in an area that is
3 identified by the Secretary under paragraph (1).''.
4 (h) TRANSITIONAL EXTRA BENEFITS.—Section 1853
5 of the Social Security Act (42 U.S.C. 1395w–23), as
6 amended by subsections (f) and (g), is amended by adding
7 at the end the following new subsection:
8 ''(p) TRANSITIONAL EXTRA BENEFITS.—
9 ''(1) IN GENERAL.—For years beginning with
10 2012, the Secretary shall provide transitional re-
11 bates under section 1854(b)(1)(C) for the provision
12 of extra benefits (as specified by the Secretary) to
13 enrollees described in paragraph (2).
14 ''(2) ENROLLEES DESCRIBED.—An enrollee de-
15 scribed in this paragraph is an individual who—
16 ''(A) enrolls in an MA local plan in an ap-
17 plicable area; and
18 ''(B) experiences a significant reduction in
19 extra benefits described in clause (ii) of section
20 1854(b)(1)(C) as a result of competitive bidding
21 under this part (as determined by the Sec-
22 retary).
23 ''(3) APPLICABLE AREAS.—In this subsection,
24 the term 'applicable area' means the following:

1 "(A) The 2 largest metropolitan statistical
2 areas, if the Secretary determines that the total
3 amount of such extra benefits for each enrollee
4 for the month in those areas is greater than
5 $100.
6 "(B) A county where—
7 "(i) the MA area-specific non-drug
8 monthly benchmark amount for a month in
9 2011 is equal to the legacy urban floor
10 amount (as described in subsection
11 (c)(1)(B)(iii)), as determined by the Sec-
12 retary for the area for 2011;
13 "(ii) the percentage of Medicare Ad-
14 vantage eligible beneficiaries in the county
15 who are enrolled in an MA plan for 2009
16 is greater than 30 percent (as determined
17 by the Secretary); and
18 "(iii) average bids submitted by an
19 MA organization under section 1854(a) for
20 MA local plans in the county for 2011 are
21 not greater than the adjusted average per
22 capita cost for the year involved, deter-
23 mined under section 1876(a)(4), for the
24 county for individuals who are not enrolled
25 in an MA plan under this part for the

1 year, but adjusted to exclude costs attrib-
2 utable to payments under section 1848(o),
3 1886(n), and 1886(h).
4 "(C) If the Secretary determines appro-
5 priate, a county contiguous to an area or coun-
6 ty described in subparagraph (A) or (B), re-
7 spectively.
8 "(4) REVIEW OF PLAN BIDS.—In the case of a
9 bid submitted by an MA organization under section
10 1854(a) for an MA local plan in an applicable area,
11 the Secretary shall review such bid in order to en-
12 sure that extra benefits (as specified by the Sec-
13 retary) are provided to enrollees described in para-
14 graph (2).
15 "(5) FUNDING.—The Secretary shall provide
16 for the transfer from the Federal Hospital Insurance
17 Trust Fund under section 1817 and the Federal
18 Supplementary Medical Insurance Trust Fund es-
19 tablished under section 1841, in such proportion as
20 the Secretary determines appropriate, of an amount
21 not to exceed $5,000,000,000 for the period of fiscal
22 years 2012 through 2019 for the purpose of pro-
23 viding transitional rebates under section
24 1854(b)(1)(C) for the provision of extra benefits
25 under this subsection.".

(i) NONAPPLICATION OF COMPETITIVE BIDDING AND RELATED PROVISIONS AND CLARIFICATION OF MA PAYMENT AREA FOR PACE PROGRAMS.—

(1) NONAPPLICATION OF COMPETITIVE BIDDING AND RELATED PROVISIONS FOR PACE PROGRAMS.—Section 1894 of the Social Security Act (42 U.S.C. 1395eee) is amended—

(A) by redesignating subsections (h) and (i) as subsections (i) and (j), respectively;

(B) by inserting after subsection (g) the following new subsection:

''(h) NONAPPLICATION OF COMPETITIVE BIDDING AND RELATED PROVISIONS UNDER PART C.—With respect to a PACE program under this section, the following provisions (and regulations relating to such provisions) shall not apply:

''(1) Section 1853(j)(1)(A)(i), relating to MA area-specific non-drug monthly benchmark amount being based on competitive bids.

''(2) Section 1853(d)(5), relating to the establishment of MA local plan service areas.

''(3) Section 1853(n), relating to the payment of performance bonuses.

"(4) Section 1853(o), relating to grandfathering supplemental benefits for current enrollees after implementation of competitive bidding.

"(5) Section 1853(p), relating to transitional extra benefits.".

(2) SPECIAL RULE FOR MA PAYMENT AREA FOR PACE PROGRAMS.—Section 1853(d) of the Social Security Act (42 U.S.C. 1395w–23(d)), as amended by subsection (e), is amended by adding at the end the following new paragraph:

"(6) SPECIAL RULE FOR MA PAYMENT AREA FOR PACE PROGRAMS.—For years beginning with 2012, in the case of a PACE program under section 1894, the MA payment area shall be the MA local area (as defined in paragraph (2)).".

SEC. 3202. BENEFIT PROTECTION AND SIMPLIFICATION.

(a) LIMITATION ON VARIATION OF COST SHARING FOR CERTAIN BENEFITS.—

(1) IN GENERAL.—Section 1852(a)(1)(B) of the Social Security Act (42 U.S.C. 1395w–22(a)(1)(B)) is amended—

(A) in clause (i), by inserting ", subject to clause (iii)," after "and B or"; and

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

"(iii) LIMITATION ON VARIATION OF COST SHARING FOR CERTAIN BENEFITS.—Subject to clause (v), cost-sharing for services described in clause (iv) shall not exceed the cost-sharing required for those services under parts A and B.

"(iv) SERVICES DESCRIBED.—The following services are described in this clause:

"(I) Chemotherapy administration services.

"(II) Renal dialysis services (as defined in section 1881(b)(14)(B)).

"(III) Skilled nursing care.

"(IV) Such other services that the Secretary determines appropriate (including services that the Secretary determines require a high level of predictability and transparency for beneficiaries).

"(v) EXCEPTION.—In the case of services described in clause (iv) for which there is no cost-sharing required under parts A and B, cost-sharing may be required for those services in accordance with clause (i).".

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to plan years beginning on or after January 1, 2011.

(b) APPLICATION OF REBATES, PERFORMANCE BONUSES, AND PREMIUMS.—

(1) APPLICATION OF REBATES.—Section 1854(b)(1)(C) of the Social Security Act (42 U.S.C. 1395w–24(b)(1)(C)) is amended—

(A) in clause (ii), by striking ''REBATE.—A rebate'' and inserting ''REBATE FOR PLAN YEARS BEFORE 2012.—For plan years before 2012, a rebate'';

(B) by redesignating clauses (iii) and (iv) as clauses (iv) and (v); and

(C) by inserting after clause (ii) the following new clause:

''(iii) FORM OF REBATE FOR PLAN YEAR 2012 AND SUBSEQUENT PLAN YEARS.—For plan years beginning on or after January 1, 2012, a rebate required under this subparagraph may not be used for the purpose described in clause (ii)(III) and shall be provided through the application of the amount of the rebate in the following priority order:

1 "(I) First, to use the most sig-
2 nificant share to meaningfully reduce
3 cost-sharing otherwise applicable for
4 benefits under the original medicare
5 fee-for-service program under parts A
6 and B and for qualified prescription
7 drug coverage under part D, including
8 the reduction of any deductibles, co-
9 payments, and maximum limitations
10 on out-of-pocket expenses otherwise
11 applicable. Any reduction of maximum
12 limitations on out-of-pocket expenses
13 under the preceding sentence shall
14 apply to all benefits under the original
15 medicare fee-for-service program op-
16 tion. The Secretary may provide guid-
17 ance on meaningfully reducing cost-
18 sharing under this subclause, except
19 that such guidance may not require a
20 particular amount of cost-sharing or
21 reduction in cost-sharing.
22 "(II) Second, to use the next
23 most significant share to meaningfully
24 provide coverage of preventive and
25 wellness health care benefits (as de-

fined by the Secretary) which are not benefits under the original medicare fee-for-service program, such as smoking cessation, a free flu shot, and an annual physical examination.

"(III) Third, to use the remaining share to meaningfully provide coverage of other health care benefits which are not benefits under the original medicare fee-for-service program, such as eye examinations and dental coverage, and are not benefits described in subclause (II).".

(2) APPLICATION OF PERFORMANCE BONUSES.—Section 1853(n) of the Social Security Act, as added by section 3201(f), is amended by adding at the end the following new paragraph:

"(6) APPLICATION OF PERFORMANCE BONUSES.—For plan years beginning on or after January 1, 2014, any performance bonus paid to an MA plan under this subsection shall be used for the purposes, and in the priority order, described in subclauses (I) through (III) of section 1854(b)(1)(C)(iii).".

(3) APPLICATION OF MA MONTHLY SUPPLEMENTARY BENEFICIARY PREMIUM.—Section 1854(b)(2)(C) of the Social Security Act (42 U.S.C. 1395w–24(b)(2)(C)) is amended—

(A) by striking ''PREMIUM.—The term'' and inserting ''PREMIUM.—

''(i) IN GENERAL.—The term''; and

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

''(ii) APPLICATION OF MA MONTHLY SUPPLEMENTARY BENEFICIARY PREMIUM.—For plan years beginning on or after January 1, 2012, any MA monthly supplementary beneficiary premium charged to an individual enrolled in an MA plan shall be used for the purposes, and in the priority order, described in subclauses (I) through (III) of paragraph (1)(C)(iii).''.

SEC. 3203. APPLICATION OF CODING INTENSITY ADJUSTMENT DURING MA PAYMENT TRANSITION.

Section 1853(a)(1)(C) of the Social Security Act (42 U.S.C. 1395w–23(a)(1)(C)) is amended by adding at the end the following new clause:

"(iii) APPLICATION OF CODING INTENSITY ADJUSTMENT FOR 2011 AND SUBSEQUENT YEARS.—

"(I) REQUIREMENT TO APPLY IN 2011 THROUGH 2013.—In order to ensure payment accuracy, the Secretary shall conduct an analysis of the differences described in clause (ii)(I). The Secretary shall ensure that the results of such analysis are incorporated into the risk scores for 2011, 2012, and 2013.

"(II) AUTHORITY TO APPLY IN 2014 AND SUBSEQUENT YEARS.—The Secretary may, as appropriate, incorporate the results of such analysis into the risk scores for 2014 and subsequent years.".

SEC. 3204. SIMPLIFICATION OF ANNUAL BENEFICIARY ELECTION PERIODS.

(a) ANNUAL 45-DAY PERIOD FOR DISENROLLMENT FROM MA PLANS TO ELECT TO RECEIVE BENEFITS UNDER THE ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM.—

(1) IN GENERAL.—Section 1851(e)(2)(C) of the Social Security Act (42 U.S.C. 1395w–1(e)(2)(C)) is amended to read as follows:

"(C) ANNUAL 45-DAY PERIOD FOR DISENROLLMENT FROM MA PLANS TO ELECT TO RECEIVE BENEFITS UNDER THE ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM.—Subject to subparagraph (D), at any time during the first 45 days of a year (beginning with 2011), an individual who is enrolled in a Medicare Advantage plan may change the election under subsection (a)(1), but only with respect to coverage under the original medicare fee-for-service program under parts A and B, and may elect qualified prescription drug coverage in accordance with section 1860D–1.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply with respect to 2011 and succeeding years.

(b) TIMING OF THE ANNUAL, COORDINATED ELECTION PERIOD UNDER PARTS C AND D.—Section 1851(e)(3)(B) of the Social Security Act (42 U.S.C. 1395w–1(e)(3)(B)) is amended—

(1) in clause (iii), by striking "and" at the end;

(2) in clause (iv)—

(A) by striking ''and succeeding years'' and inserting '', 2008, 2009, and 2010''; and

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

(3) by adding at the end the following new clause:

''(v) with respect to 2012 and succeeding years, the period beginning on October 15 and ending on December 7 of the year before such year.''.

SEC. 3205. EXTENSION FOR SPECIALIZED MA PLANS FOR SPECIAL NEEDS INDIVIDUALS.

(a) EXTENSION OF SNP AUTHORITY.—Section 1859(f)(1) of the Social Security Act (42 U.S.C. 1395w–28(f)(1)), as amended by section 164(a) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275), is amended by striking ''2011'' and inserting ''2014''.

(b) AUTHORITY TO APPLY FRAILTY ADJUSTMENT UNDER PACE PAYMENT RULES.—Section 1853(a)(1)(B) of the Social Security Act (42 U.S.C. 1395w–23(a)(1)(B)) is amended by adding at the end the following new clause:

''(iv) AUTHORITY TO APPLY FRAILTY ADJUSTMENT UNDER PACE PAYMENT RULES FOR CERTAIN SPECIALIZED MA

1 PLANS FOR SPECIAL NEEDS INDIVID-
2 UALS.—
3 "(I) IN GENERAL.—Notwith-
4 standing the preceding provisions of
5 this paragraph, for plan year 2011
6 and subsequent plan years, in the case
7 of a plan described in subclause (II),
8 the Secretary may apply the payment
9 rules under section 1894(d) (other
10 than paragraph (3) of such section)
11 rather than the payment rules that
12 would otherwise apply under this part,
13 but only to the extent necessary to re-
14 flect the costs of treating high con-
15 centrations of frail individuals.
16 "(II) PLAN DESCRIBED.—A plan
17 described in this subclause is a spe-
18 cialized MA plan for special needs in-
19 dividuals described in section
20 1859(b)(6)(B)(ii) that is fully inte-
21 grated with capitated contracts with
22 States for Medicaid benefits, including
23 long-term care, and that have similar
24 average levels of frailty (as deter-

mined by the Secretary) as the PACE program.''.

(c) TRANSITION AND EXCEPTION REGARDING RESTRICTION ON ENROLLMENT.—Section 1859(f) of the Social Security Act (42 U.S.C. 1395w–28(f)) is amended by adding at the end the following new paragraph:

''(6) TRANSITION AND EXCEPTION REGARDING RESTRICTION ON ENROLLMENT.—

''(A) IN GENERAL.—Subject to subparagraph (C), the Secretary shall establish procedures for the transition of applicable individuals to—

''(i) a Medicare Advantage plan that is not a specialized MA plan for special needs individuals (as defined in subsection (b)(6)); or

''(ii) the original medicare fee-for-service program under parts A and B.

''(B) APPLICABLE INDIVIDUALS.—For purposes of clause (i), the term 'applicable individual' means an individual who—

''(i) is enrolled under a specialized MA plan for special needs individuals (as defined in subsection (b)(6)); and

"(ii) is not within the 1 or more of the classes of special needs individuals to which enrollment under the plan is restricted to.

"(C) EXCEPTION.—The Secretary shall provide for an exception to the transition described in subparagraph (A) for a limited period of time for individuals enrolled under a specialized MA plan for special needs individuals described in subsection (b)(6)(B)(ii) who are no longer eligible for medical assistance under title XIX.

"(D) TIMELINE FOR INITIAL TRANSITION.—The Secretary shall ensure that applicable individuals enrolled in a specialized MA plan for special needs individuals (as defined in subsection (b)(6)) prior to January 1, 2010, are transitioned to a plan or the program described in subparagraph (A) by not later than January 1, 2013.".

(d) TEMPORARY EXTENSION OF AUTHORITY TO OPERATE BUT NO SERVICE AREA EXPANSION FOR DUAL SPECIAL NEEDS PLANS THAT DO NOT MEET CERTAIN REQUIREMENTS.—Section 164(c)(2) of the Medicare Improvements for Patients and Providers Act of 2008 (Pub-

lic Law 110–275) is amended by striking ''December 31, 2010'' and inserting ''December 31, 2012''.

(e) AUTHORITY TO REQUIRE SPECIAL NEEDS PLANS BE NCQA APPROVED.—Section 1859(f) of the Social Security Act (42 U.S.C. 1395w–28(f)), as amended by subsections (a) and (c), is amended—

(1) in paragraph (2), by adding at the end the following new subparagraph:

''(C) If applicable, the plan meets the requirement described in paragraph (7).'';

(2) in paragraph (3), by adding at the end the following new subparagraph:

''(E) If applicable, the plan meets the requirement described in paragraph (7).'';

(3) in paragraph (4), by adding at the end the following new subparagraph:

''(C) If applicable, the plan meets the requirement described in paragraph (7).''; and

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

''(7) AUTHORITY TO REQUIRE SPECIAL NEEDS PLANS BE NCQA APPROVED.—For 2012 and subsequent years, the Secretary shall require that a Medicare Advantage organization offering a specialized MA plan for special needs individuals be approved

by the National Committee for Quality Assurance (based on standards established by the Secretary).''.

(f) RISK ADJUSTMENT.—Section 1853(a)(1)(C) of the Social Security Act (42 U.S.C. 1395i–23(a)(1)(C)) is amended by adding at the end the following new clause:

''(iii) IMPROVEMENTS TO RISK ADJUSTMENT FOR SPECIAL NEEDS INDIVIDUALS WITH CHRONIC HEALTH CONDITIONS.—

''(I) IN GENERAL.—For 2011 and subsequent years, for purposes of the adjustment under clause (i) with respect to individuals described in subclause (II), the Secretary shall use a risk score that reflects the known underlying risk profile and chronic health status of similar individuals. Such risk score shall be used instead of the default risk score for new enrollees in Medicare Advantage plans that are not specialized MA plans for special needs individuals (as defined in section 1859(b)(6)).

''(II) INDIVIDUALS DESCRIBED.—An individual described in

this subclause is a special needs individual described in subsection (b)(6)(B)(iii) who enrolls in a specialized MA plan for special needs individuals on or after January 1, 2011.

"(III) EVALUATION.—For 2011 and periodically thereafter, the Secretary shall evaluate and revise the risk adjustment system under this subparagraph in order to, as accurately as possible, account for higher medical and care coordination costs associated with frailty, individuals with multiple, comorbid chronic conditions, and individuals with a diagnosis of mental illness, and also to account for costs that may be associated with higher concentrations of beneficiaries with those conditions.

"(IV) PUBLICATION OF EVALUATION AND REVISIONS.—The Secretary shall publish, as part of an announcement under subsection (b), a description of any evaluation conducted under subclause (III) during the pre-

ceding year and any revisions made under such subclause as a result of such evaluation.''.

(g) TECHNICAL CORRECTION.—Section 1859(f)(5) of the Social Security Act (42 U.S.C. 1395w–28(f)(5)) is amended, in the matter preceding subparagraph (A), by striking ''described in subsection (b)(6)(B)(i)''.

SEC. 3206. EXTENSION OF REASONABLE COST CONTRACTS.

Section 1876(h)(5)(C)(ii) of the Social Security Act (42 U.S.C. 1395mm(h)(5)(C)(ii)) is amended, in the matter preceding subclause (I), by striking ''January 1, 2010'' and inserting ''January 1, 2013''.

SEC. 3207. TECHNICAL CORRECTION TO MA PRIVATE FEE-FOR-SERVICE PLANS.

For plan year 2011 and subsequent plan years, to the extent that the Secretary of Health and Human Services is applying the 2008 service area extension waiver policy (as modified in the April 11, 2008, Centers for Medicare & Medicaid Services' memorandum with the subject ''2009 Employer Group Waiver-Modification of the 2008 Service Area Extension Waiver Granted to Certain MA Local Coordinated Care Plans'') to Medicare Advantage coordinated care plans, the Secretary shall extend the application of such waiver policy to employers who contract directly with the Secretary as a Medicare Advantage pri-

1 vate fee-for-service plan under section 1857(i)(2) of the
2 Social Security Act (42 U.S.C. 1395w–27(i)(2)) and that
3 had enrollment as of October 1, 2009.

4 **SEC. 3208. MAKING SENIOR HOUSING FACILITY DEM-**
5 **ONSTRATION PERMANENT.**

6 (a) IN GENERAL.—Section 1859 of the Social Secu-
7 rity Act (42 U.S.C. 1395w–28) is amended by adding at
8 the end the following new subsection:

9 ''(g) SPECIAL RULES FOR SENIOR HOUSING FACIL-
10 ITY PLANS.—

11 ''(1) IN GENERAL.—In the case of a Medicare
12 Advantage senior housing facility plan described in
13 paragraph (2), notwithstanding any other provision
14 of this part to the contrary and in accordance with
15 regulations of the Secretary, the service area of such
16 plan may be limited to a senior housing facility in
17 a geographic area.

18 ''(2) MEDICARE ADVANTAGE SENIOR HOUSING
19 FACILITY PLAN DESCRIBED.—For purposes of this
20 subsection, a Medicare Advantage senior housing fa-
21 cility plan is a Medicare Advantage plan that—

22 ''(A) restricts enrollment of individuals
23 under this part to individuals who reside in a
24 continuing care retirement community (as de-
25 fined in section 1852(l)(4)(B));

"(B) provides primary care services onsite and has a ratio of accessible physicians to beneficiaries that the Secretary determines is adequate;

"(C) provides transportation services for beneficiaries to specialty providers outside of the facility; and

"(D) has participated (as of December 31, 2009) in a demonstration project established by the Secretary under which such a plan was offered for not less than 1 year.".

(b) EFFECTIVE DATE.—The amendment made by this section shall take effect on January 1, 2010, and shall apply to plan years beginning on or after such date.

SEC. 3209. AUTHORITY TO DENY PLAN BIDS.

(a) IN GENERAL.—Section 1854(a)(5) of the Social Security Act (42 U.S.C. 1395w–24(a)(5)) is amended by adding at the end the following new subparagraph:

"(C) REJECTION OF BIDS.—

"(i) IN GENERAL.—Nothing in this section shall be construed as requiring the Secretary to accept any or every bid submitted by an MA organization under this subsection.

"(ii) AUTHORITY TO DENY BIDS THAT PROPOSE SIGNIFICANT INCREASES IN COST SHARING OR DECREASES IN BENEFITS.—The Secretary may deny a bid submitted by an MA organization for an MA plan if it proposes significant increases in cost sharing or decreases in benefits offered under the plan.".

(b) APPLICATION UNDER PART D.—Section 1860D–11(d) of such Act (42 U.S.C. 1395w–111(d)) is amended by adding at the end the following new paragraph:

"(3) REJECTION OF BIDS.—Paragraph (5)(C) of section 1854(a) shall apply with respect to bids submitted by a PDP sponsor under subsection (b) in the same manner as such paragraph applies to bids submitted by an MA organization under such section 1854(a).".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to bids submitted for contract years beginning on or after January 1, 2011.

SEC. 3210. DEVELOPMENT OF NEW STANDARDS FOR CERTAIN MEDIGAP PLANS.

(a) IN GENERAL.—Section 1882 of the Social Security Act (42 U.S.C. 1395ss) is amended by adding at the end the following new subsection:

1 "(y) DEVELOPMENT OF NEW STANDARDS FOR CER-
2 TAIN MEDICARE SUPPLEMENTAL POLICIES.—
3 "(1) IN GENERAL.—The Secretary shall request
4 the National Association of Insurance Commis-
5 sioners to review and revise the standards for benefit
6 packages described in paragraph (2) under sub-
7 section (p)(1), to otherwise update standards to in-
8 clude requirements for nominal cost sharing to en-
9 courage the use of appropriate physicians' services
10 under part B. Such revisions shall be based on evi-
11 dence published in peer-reviewed journals or current
12 examples used by integrated delivery systems and
13 made consistent with the rules applicable under sub-
14 section (p)(1)(E) with the reference to the '1991
15 NAIC Model Regulation' deemed a reference to the
16 NAIC Model Regulation as published in the Federal
17 Register on December 4, 1998, and as subsequently
18 updated by the National Association of Insurance
19 Commissioners to reflect previous changes in law
20 and the reference to 'date of enactment of this sub-
21 section' deemed a reference to the date of enactment
22 of the Patient Protection and Affordable Care Act.
23 To the extent practicable, such revision shall provide
24 for the implementation of revised standards for ben-
25 efit packages as of January 1, 2015.

"(2) BENEFIT PACKAGES DESCRIBED.—The benefit packages described in this paragraph are benefit packages classified as 'C' and 'F'.".

(b) CONFORMING AMENDMENT.—Section 1882(o)(1) of the Social Security Act (42 U.S.C. 1395ss(o)(1)) is amended by striking ", and (w)" and inserting "(w), and (y)".

Subtitle D—Medicare Part D Improvements for Prescription Drug Plans and MA–PD Plans

SEC. 3301. MEDICARE COVERAGE GAP DISCOUNT PROGRAM.

(a) CONDITION FOR COVERAGE OF DRUGS UNDER PART D.—Part D of Title XVIII of the Social Security Act (42 U.S.C. 1395w–101 et seq.), is amended by adding at the end the following new section:

"CONDITION FOR COVERAGE OF DRUGS UNDER THIS PART

"SEC. 1860D–43. (a) IN GENERAL.—In order for coverage to be available under this part for covered part D drugs (as defined in section 1860D–2(e)) of a manufacturer, the manufacturer must—

"(1) participate in the Medicare coverage gap discount program under section 1860D–14A;

"(2) have entered into and have in effect an agreement described in subsection (b) of such section with the Secretary; and

"(3) have entered into and have in effect, under terms and conditions specified by the Secretary, a contract with a third party that the Secretary has entered into a contract with under subsection (d)(3) of such section.

"(b) EFFECTIVE DATE.—Subsection (a) shall apply to covered part D drugs dispensed under this part on or after July 1, 2010.

"(c) AUTHORIZING COVERAGE FOR DRUGS NOT COVERED UNDER AGREEMENTS.—Subsection (a) shall not apply to the dispensing of a covered part D drug if—

"(1) the Secretary has made a determination that the availability of the drug is essential to the health of beneficiaries under this part; or

"(2) the Secretary determines that in the period beginning on July 1, 2010, and ending on December 31, 2010, there were extenuating circumstances.

"(d) DEFINITION OF MANUFACTURER.—In this section, the term 'manufacturer' has the meaning given such term in section 1860D–14A(g)(5).".

(b) MEDICARE COVERAGE GAP DISCOUNT PROGRAM.—Part D of title XVIII of the Social Security Act

1 (42 U.S.C. 1395w–101) is amended by inserting after sec-
2 tion 1860D–14 the following new section:

3 "MEDICARE COVERAGE GAP DISCOUNT PROGRAM

4 "SEC. 1860D–14A. (a) ESTABLISHMENT.—The Sec-
5 retary shall establish a Medicare coverage gap discount
6 program (in this section referred to as the 'program') by
7 not later than July 1, 2010. Under the program, the Sec-
8 retary shall enter into agreements described in subsection
9 (b) with manufacturers and provide for the performance
10 of the duties described in subsection (c)(1). The Secretary
11 shall establish a model agreement for use under the pro-
12 gram by not later than April 1, 2010, in consultation with
13 manufacturers, and allow for comment on such model
14 agreement.

15 "(b) TERMS OF AGREEMENT.—

16 "(1) IN GENERAL.—

17 "(A) AGREEMENT.—An agreement under
18 this section shall require the manufacturer to
19 provide applicable beneficiaries access to dis-
20 counted prices for applicable drugs of the man-
21 ufacturer.

22 "(B) PROVISION OF DISCOUNTED PRICES
23 AT THE POINT-OF-SALE.—Except as provided in
24 subsection (c)(1)(A)(iii), such discounted prices
25 shall be provided to the applicable beneficiary at

the pharmacy or by the mail order service at the point-of-sale of an applicable drug.

"(C) TIMING OF AGREEMENT.—

"(i) SPECIAL RULE FOR 2010 AND 2011.—In order for an agreement with a manufacturer to be in effect under this section with respect to the period beginning on July 1, 2010, and ending on December 31, 2011, the manufacturer shall enter into such agreement not later than May 1, 2010.

"(ii) 2012 AND SUBSEQUENT YEARS.—In order for an agreement with a manufacturer to be in effect under this section with respect to plan year 2012 or a subsequent plan year, the manufacturer shall enter into such agreement (or such agreement shall be renewed under paragraph (4)(A)) not later than January 30 of the preceding year.

"(2) PROVISION OF APPROPRIATE DATA.—Each manufacturer with an agreement in effect under this section shall collect and have available appropriate data, as determined by the Secretary, to ensure that

it can demonstrate to the Secretary compliance with the requirements under the program.

"(3) COMPLIANCE WITH REQUIREMENTS FOR ADMINISTRATION OF PROGRAM.—Each manufacturer with an agreement in effect under this section shall comply with requirements imposed by the Secretary or a third party with a contract under subsection (d)(3), as applicable, for purposes of administering the program, including any determination under clause (i) of subsection (c)(1)(A) or procedures established under such subsection (c)(1)(A).

"(4) LENGTH OF AGREEMENT.—

"(A) IN GENERAL.—An agreement under this section shall be effective for an initial period of not less than 18 months and shall be automatically renewed for a period of not less than 1 year unless terminated under subparagraph (B).

"(B) TERMINATION.—

"(i) BY THE SECRETARY.—The Secretary may provide for termination of an agreement under this section for a knowing and willful violation of the requirements of the agreement or other good cause shown. Such termination shall not be effective ear-

lier than 30 days after the date of notice to the manufacturer of such termination. The Secretary shall provide, upon request, a manufacturer with a hearing concerning such a termination, and such hearing shall take place prior to the effective date of the termination with sufficient time for such effective date to be repealed if the Secretary determines appropriate.

''(ii) BY A MANUFACTURER.—A manufacturer may terminate an agreement under this section for any reason. Any such termination shall be effective, with respect to a plan year—

''(I) if the termination occurs before January 30 of a plan year, as of the day after the end of the plan year; and

''(II) if the termination occurs on or after January 30 of a plan year, as of the day after the end of the succeeding plan year.

''(iii) EFFECTIVENESS OF TERMINATION.—Any termination under this subparagraph shall not affect discounts for

applicable drugs of the manufacturer that are due under the agreement before the effective date of its termination.

"(iv) NOTICE TO THIRD PARTY.—The Secretary shall provide notice of such termination to a third party with a contract under subsection (d)(3) within not less than 30 days before the effective date of such termination.

"(e) DUTIES DESCRIBED AND SPECIAL RULE FOR SUPPLEMENTAL BENEFITS.—

"(1) DUTIES DESCRIBED.—The duties described in this subsection are the following:

"(A) ADMINISTRATION OF PROGRAM.—Administering the program, including—

"(i) the determination of the amount of the discounted price of an applicable drug of a manufacturer;

"(ii) except as provided in clause (iii), the establishment of procedures under which discounted prices are provided to applicable beneficiaries at pharmacies or by mail order service at the point-of-sale of an applicable drug;

1 "(iii) in the case where, during the pe-
2 riod beginning on July 1, 2010, and end-
3 ing on December 31, 2011, it is not prac-
4 ticable to provide such discounted prices at
5 the point-of-sale (as described in clause
6 (ii)), the establishment of procedures to
7 provide such discounted prices as soon as
8 practicable after the point-of-sale;
9 "(iv) the establishment of procedures
10 to ensure that, not later than the applica-
11 ble number of calendar days after the dis-
12 pensing of an applicable drug by a phar-
13 macy or mail order service, the pharmacy
14 or mail order service is reimbursed for an
15 amount equal to the difference between—
16 "(I) the negotiated price of the
17 applicable drug; and
18 "(II) the discounted price of the
19 applicable drug;
20 "(v) the establishment of procedures
21 to ensure that the discounted price for an
22 applicable drug under this section is ap-
23 plied before any coverage or financial as-
24 sistance under other health benefit plans
25 or programs that provide coverage or fi-

1 nancial assistance for the purchase or pro-
2 vision of prescription drug coverage on be-
3 half of applicable beneficiaries as the Sec-
4 retary may specify;
5 ''(vi) the establishment of procedures
6 to implement the special rule for supple-
7 mental benefits under paragraph (2); and
8 ''(vii) providing a reasonable dispute
9 resolution mechanism to resolve disagree-
10 ments between manufacturers, applicable
11 beneficiaries, and the third party with a
12 contract under subsection (d)(3).
13 ''(B) MONITORING COMPLIANCE.—
14 ''(i) IN GENERAL.—The Secretary
15 shall monitor compliance by a manufac-
16 turer with the terms of an agreement
17 under this section.
18 ''(ii) NOTIFICATION.—If a third party
19 with a contract under subsection (d)(3) de-
20 termines that the manufacturer is not in
21 compliance with such agreement, the third
22 party shall notify the Secretary of such
23 noncompliance for appropriate enforcement
24 under subsection (e).

"(C) COLLECTION OF DATA FROM PRESCRIPTION DRUG PLANS AND MA–PD PLANS.—The Secretary may collect appropriate data from prescription drug plans and MA–PD plans in a timeframe that allows for discounted prices to be provided for applicable drugs under this section.

"(2) SPECIAL RULE FOR SUPPLEMENTAL BENEFITS.—For plan year 2010 and each subsequent plan year, in the case where an applicable beneficiary has supplemental benefits with respect to applicable drugs under the prescription drug plan or MA–PD plan that the applicable beneficiary is enrolled in, the applicable beneficiary shall not be provided a discounted price for an applicable drug under this section until after such supplemental benefits have been applied with respect to the applicable drug.

"(d) ADMINISTRATION.—

"(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall provide for the implementation of this section, including the performance of the duties described in subsection (c)(1).

"(2) LIMITATION.—

"(A) IN GENERAL.—Subject to subparagraph (B), in providing for such implementation, the Secretary shall not receive or distribute any funds of a manufacturer under the program.

"(B) EXCEPTION.—The limitation under subparagraph (A) shall not apply to the Secretary with respect to drugs dispensed during the period beginning on July 1, 2010, and ending on December 31, 2010, but only if the Secretary determines that the exception to such limitation under this subparagraph is necessary in order for the Secretary to begin implementation of this section and provide applicable beneficiaries timely access to discounted prices during such period.

"(3) CONTRACT WITH THIRD PARTIES.—The Secretary shall enter into a contract with 1 or more third parties to administer the requirements established by the Secretary in order to carry out this section. At a minimum, the contract with a third party under the preceding sentence shall require that the third party—

"(A) receive and transmit information between the Secretary, manufacturers, and other

individuals or entities the Secretary determines appropriate;

"(B) receive, distribute, or facilitate the distribution of funds of manufacturers to appropriate individuals or entities in order to meet the obligations of manufacturers under agreements under this section;

"(C) provide adequate and timely information to manufacturers, consistent with the agreement with the manufacturer under this section, as necessary for the manufacturer to fulfill its obligations under this section; and

"(D) permit manufacturers to conduct periodic audits, directly or through contracts, of the data and information used by the third party to determine discounts for applicable drugs of the manufacturer under the program.

"(4) PERFORMANCE REQUIREMENTS.—The Secretary shall establish performance requirements for a third party with a contract under paragraph (3) and safeguards to protect the independence and integrity of the activities carried out by the third party under the program under this section.

1 "(5) IMPLEMENTATION.—The Secretary may
2 implement the program under this section by pro-
3 gram instruction or otherwise.
4 "(6) ADMINISTRATION.—Chapter 35 of title 44,
5 United States Code, shall not apply to the program
6 under this section.
7 "(e) ENFORCEMENT.—
8 "(1) AUDITS.—Each manufacturer with an
9 agreement in effect under this section shall be sub-
10 ject to periodic audit by the Secretary.
11 "(2) CIVIL MONEY PENALTY.—
12 "(A) IN GENERAL.—The Secretary shall
13 impose a civil money penalty on a manufacturer
14 that fails to provide applicable beneficiaries dis-
15 counts for applicable drugs of the manufacturer
16 in accordance with such agreement for each
17 such failure in an amount the Secretary deter-
18 mines is commensurate with the sum of—
19 "(i) the amount that the manufac-
20 turer would have paid with respect to such
21 discounts under the agreement, which will
22 then be used to pay the discounts which
23 the manufacturer had failed to provide;
24 and
25 "(ii) 25 percent of such amount.

"(B) APPLICATION.—The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under this paragraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

"(f) CLARIFICATION REGARDING AVAILABILITY OF OTHER COVERED PART D DRUGS.—Nothing in this section shall prevent an applicable beneficiary from purchasing a covered part D drug that is not an applicable drug (including a generic drug or a drug that is not on the formulary of the prescription drug plan or MA–PD plan that the applicable beneficiary is enrolled in).

"(g) DEFINITIONS.—In this section:

"(1) APPLICABLE BENEFICIARY.—The term 'applicable beneficiary' means an individual who, on the date of dispensing an applicable drug—

"(A) is enrolled in a prescription drug plan or an MA–PD plan;

"(B) is not enrolled in a qualified retiree prescription drug plan;

"(C) is not entitled to an income-related subsidy under section 1860D–14(a);

"(D) is not subject to a reduction in premium subsidy under section 1839(i); and

"(E) who—

"(i) has reached or exceeded the initial coverage limit under section 1860D–2(b)(3) during the year; and

"(ii) has not incurred costs for covered part D drugs in the year equal to the annual out-of-pocket threshold specified in section 1860D–2(b)(4)(B).

"(2) APPLICABLE DRUG.—The term 'applicable drug' means, with respect to an applicable beneficiary, a covered part D drug—

"(A) approved under a new drug application under section 505(b) of the Federal Food, Drug, and Cosmetic Act or, in the case of a biologic product, licensed under section 351 of the Public Health Service Act (other than a product licensed under subsection (k) of such section 351); and

"(B)(i) if the PDP sponsor of the prescription drug plan or the MA organization offering the MA–PD plan uses a formulary, which is on the formulary of the prescription drug plan or MA–PD plan that the applicable beneficiary is enrolled in;

"(ii) if the PDP sponsor of the prescription drug plan or the MA organization offering the MA–PD plan does not use a formulary, for which benefits are available under the prescription drug plan or MA–PD plan that the applicable beneficiary is enrolled in; or

"(iii) is provided through an exception or appeal.

"(3) APPLICABLE NUMBER OF CALENDAR DAYS.—The term 'applicable number of calendar days' means—

"(A) with respect to claims for reimbursement submitted electronically, 14 days; and

"(B) with respect to claims for reimbursement submitted otherwise, 30 days.

"(4) DISCOUNTED PRICE.—

"(A) IN GENERAL.—The term 'discounted price' means 50 percent of the negotiated price of the applicable drug of a manufacturer.

"(B) CLARIFICATION.—Nothing in this section shall be construed as affecting the responsibility of an applicable beneficiary for payment of a dispensing fee for an applicable drug.

"(C) SPECIAL CASE FOR CERTAIN CLAIMS.—In the case where the entire amount

of the negotiated price of an individual claim for an applicable drug with respect to an applicable beneficiary does not fall at or above the initial coverage limit under section 1860D-2(b)(3) and below the annual out-of-pocket threshold specified in section 1860D-2(b)(4)(B) for the year, the manufacturer of the applicable drug shall provide the discounted price under this section on only the portion of the negotiated price of the applicable drug that falls at or above such initial coverage limit and below such annual out-of-pocket threshold.

''(5) MANUFACTURER.—The term 'manufacturer' means any entity which is engaged in the production, preparation, propagation, compounding, conversion, or processing of prescription drug products, either directly or indirectly by extraction from substances of natural origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis. Such term does not include a wholesale distributor of drugs or a retail pharmacy licensed under State law.

''(6) NEGOTIATED PRICE.—The term 'negotiated price' has the meaning given such term in section 423.100 of title 42, Code of Federal Regula-

tions (as in effect on the date of enactment of this section), except that such negotiated price shall not include any dispensing fee for the applicable drug.

"(7) QUALIFIED RETIREE PRESCRIPTION DRUG PLAN.—The term 'qualified retiree prescription drug plan' has the meaning given such term in section 1860D–22(a)(2).".

(c) INCLUSION IN INCURRED COSTS.—

(1) IN GENERAL.—Section 1860D–2(b)(4) of the Social Security Act (42 U.S.C. 1395w–102(b)(4)) is amended—

(A) in subparagraph (C), in the matter preceding clause (i), by striking "In applying" and inserting "Except as provided in subparagraph (E), in applying"; and

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

"(E) INCLUSION OF COSTS OF APPLICABLE DRUGS UNDER MEDICARE COVERAGE GAP DISCOUNT PROGRAM.—In applying subparagraph (A), incurred costs shall include the negotiated price (as defined in paragraph (6) of section 1860D–14A(g)) of an applicable drug (as defined in paragraph (2) of such section) of a manufacturer that is furnished to an applicable

1 beneficiary (as defined in paragraph (1) of such
2 section) under the Medicare coverage gap dis-
3 count program under section 1860D–14A, re-
4 gardless of whether part of such costs were paid
5 by a manufacturer under such program.''.
6 (2) EFFECTIVE DATE.—The amendments made
7 by this subsection shall apply to costs incurred on or
8 after July 1, 2010.
9 (d) CONFORMING AMENDMENT PERMITTING PRE-
10 SCRIPTION DRUG DISCOUNTS.—
11 (1) IN GENERAL.—Section 1128B(b)(3) of the
12 Social Security Act (42 U.S.C. 1320a–7b(b)(3)) is
13 amended—
14 (A) by striking ''and'' at the end of sub-
15 paragraph (G);
16 (B) in the subparagraph (H) added by sec-
17 tion 237(d) of the Medicare Prescription Drug,
18 Improvement, and Modernization Act of 2003
19 (Public Law 108–173; 117 Stat. 2213)—
20 (i) by moving such subparagraph 2
21 ems to the left; and
22 (ii) by striking the period at the end
23 and inserting a semicolon;
24 (C) in the subparagraph (H) added by sec-
25 tion 431(a) of such Act (117 Stat. 2287)—

(i) by redesignating such subparagraph as subparagraph (I);

(ii) by moving such subparagraph 2 ems to the left; and

(iii) by striking the period at the end and inserting "; and"; and

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

"(J) a discount in the price of an applicable drug (as defined in paragraph (2) of section 1860D–14A(g)) of a manufacturer that is furnished to an applicable beneficiary (as defined in paragraph (1) of such section) under the Medicare coverage gap discount program under section 1860D–14A.".

(2) CONFORMING AMENDMENT TO DEFINITION OF BEST PRICE UNDER MEDICAID.—Section 1927(c)(1)(C)(i)(VI) of the Social Security Act (42 U.S.C. 1396r–8(c)(1)(C)(i)(VI)) is amended by inserting ", or any discounts provided by manufacturers under the Medicare coverage gap discount program under section 1860D–14A" before the period at the end.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to drugs dispensed on or after July 1, 2010.

SEC. 3302. IMPROVEMENT IN DETERMINATION OF MEDICARE PART D LOW-INCOME BENCHMARK PREMIUM.

(a) IN GENERAL.—Section 1860D–14(b)(2)(B)(iii) of the Social Security Act (42 U.S.C. 1395w–114(b)(2)(B)(iii)) is amended by inserting ", determined without regard to any reduction in such premium as a result of any beneficiary rebate under section 1854(b)(1)(C) or bonus payment under section 1853(n)" before the period at the end.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to premiums for months beginning on or after January 1, 2011.

SEC. 3303. VOLUNTARY DE MINIMIS POLICY FOR SUBSIDY ELIGIBLE INDIVIDUALS UNDER PRESCRIPTION DRUG PLANS AND MA–PD PLANS.

(a) IN GENERAL.—Section 1860D–14(a) of the Social Security Act (42 U.S.C. 1395w–114(a)) is amended by adding at the end the following new paragraph:

"(5) WAIVER OF DE MINIMIS PREMIUMS.—The Secretary shall, under procedures established by the Secretary, permit a prescription drug plan or an

MA–PD plan to waive the monthly beneficiary premium for a subsidy eligible individual if the amount of such premium is de minimis. If such premium is waived under the plan, the Secretary shall not reassign subsidy eligible individuals enrolled in the plan to other plans based on the fact that the monthly beneficiary premium under the plan was greater than the low-income benchmark premium amount.''.

(b) AUTHORIZING THE SECRETARY TO AUTO-ENROLL SUBSIDY ELIGIBLE INDIVIDUALS IN PLANS THAT WAIVE DE MINIMIS PREMIUMS.—Section 1860D–1(b)(1) of the Social Security Act (42 U.S.C. 1395w–101(b)(1)) is amended—

(1) in subparagraph (C), by inserting ''except as provided in subparagraph (D),'' after ''shall include,''

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

''(D) SPECIAL RULE FOR PLANS THAT WAIVE DE MINIMIS PREMIUMS.—The process established under subparagraph (A) may include, in the case of a part D eligible individual who is a subsidy eligible individual (as defined in section 1860D–14(a)(3)) who has failed to enroll in a prescription drug plan or an MA–PD

plan, for the enrollment in a prescription drug plan or MA–PD plan that has waived the monthly beneficiary premium for such subsidy eligible individual under section 1860D–14(a)(5). If there is more than one such plan available, the Secretary shall enroll such an individual under the preceding sentence on a random basis among all such plans in the PDP region. Nothing in the previous sentence shall prevent such an individual from declining or changing such enrollment.''.

(c) EFFECTIVE DATE.—The amendments made by this subsection shall apply to premiums for months, and enrollments for plan years, beginning on or after January 1, 2011.

SEC. 3304. SPECIAL RULE FOR WIDOWS AND WIDOWERS REGARDING ELIGIBILITY FOR LOW-INCOME ASSISTANCE.

(a) IN GENERAL.—Section 1860D–14(a)(3)(B) of the Social Security Act (42 U.S.C. 1395w–114(a)(3)(B)) is amended by adding at the end the following new clause:

''(vi) SPECIAL RULE FOR WIDOWS AND WIDOWERS.—Notwithstanding the preceding provisions of this subparagraph, in the case of an individual whose spouse

dies during the effective period for a determination or redetermination that has been made under this subparagraph, such effective period shall be extended through the date that is 1 year after the date on which the determination or redetermination would (but for the application of this clause) otherwise cease to be effective.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on January 1, 2011.

SEC. 3305. IMPROVED INFORMATION FOR SUBSIDY ELIGIBLE INDIVIDUALS REASSIGNED TO PRESCRIPTION DRUG PLANS AND MA–PD PLANS.

Section 1860D–14 of the Social Security Act (42 U.S.C. 1395w–114) is amended—

(1) by redesignating subsection (d) as subsection (e); and

(2) by inserting after subsection (c) the following new subsection:

''(d) FACILITATION OF REASSIGNMENTS.—Beginning not later than January 1, 2011, the Secretary shall, in the case of a subsidy eligible individual who is enrolled in one prescription drug plan and is subsequently reassigned by the Secretary to a new prescription drug plan,

provide the individual, within 30 days of such reassignment, with—

"(1) information on formulary differences between the individual's former plan and the plan to which the individual is reassigned with respect to the individual's drug regimens; and

"(2) a description of the individual's right to request a coverage determination, exception, or reconsideration under section 1860D–4(g), bring an appeal under section 1860D–4(h), or resolve a grievance under section 1860D–4(f).".

SEC. 3306. FUNDING OUTREACH AND ASSISTANCE FOR LOW-INCOME PROGRAMS.

(a) ADDITIONAL FUNDING FOR STATE HEALTH INSURANCE PROGRAMS.—Subsection (a)(1)(B) of section 119 of the Medicare Improvements for Patients and Providers Act of 2008 (42 U.S.C. 1395b–3 note) is amended by striking "(42 U.S.C. 1395w–23(f))" and all that follows through the period at the end and inserting "(42 U.S.C. 1395w–23(f)), to the Centers for Medicare & Medicaid Services Program Management Account—

"(i) for fiscal year 2009, of $7,500,000; and

"(ii) for the period of fiscal years 2010 through 2012, of $15,000,000.

Amounts appropriated under this subparagraph shall remain available until expended.''.

(b) ADDITIONAL FUNDING FOR AREA AGENCIES ON AGING.—Subsection (b)(1)(B) of such section 119 is amended by striking ''(42 U.S.C. 1395w–23(f))'' and all that follows through the period at the end and inserting ''(42 U.S.C. 1395w–23(f)), to the Administration on Aging—

''(i) for fiscal year 2009, of $7,500,000; and

''(ii) for the period of fiscal years 2010 through 2012, of $15,000,000.

Amounts appropriated under this subparagraph shall remain available until expended.''.

(c) ADDITIONAL FUNDING FOR AGING AND DISABILITY RESOURCE CENTERS.—Subsection (c)(1)(B) of such section 119 is amended by striking ''(42 U.S.C. 1395w–23(f))'' and all that follows through the period at the end and inserting ''(42 U.S.C. 1395w–23(f)), to the Administration on Aging—

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

''(ii) for the period of fiscal years 2010 through 2012, of $10,000,000.

1 Amounts appropriated under this subparagraph
2 shall remain available until expended.''.
3 (d) ADDITIONAL FUNDING FOR CONTRACT WITH
4 THE NATIONAL CENTER FOR BENEFITS AND OUTREACH
5 ENROLLMENT.—Subsection (d)(2) of such section 119 is
6 amended by striking ''(42 U.S.C. 1395w–23(f))'' and all
7 that follows through the period at the end and inserting
8 ''(42 U.S.C. 1395w–23(f)), to the Administration on
9 Aging—
10 ''(i) for fiscal year 2009, of
11 $5,000,000; and
12 ''(ii) for the period of fiscal years
13 2010 through 2012, of $5,000,000.
14 Amounts appropriated under this subparagraph
15 shall remain available until expended.''.
16 (e) SECRETARIAL AUTHORITY TO ENLIST SUPPORT
17 IN CONDUCTING CERTAIN OUTREACH ACTIVITIES.—Such
18 section 119 is amended by adding at the end the following
19 new subsection:
20 ''(g) SECRETARIAL AUTHORITY TO ENLIST SUPPORT
21 IN CONDUCTING CERTAIN OUTREACH ACTIVITIES.—The
22 Secretary may request that an entity awarded a grant
23 under this section support the conduct of outreach activi-
24 ties aimed at preventing disease and promoting wellness.
25 Notwithstanding any other provision of this section, an en-

1 tity may use a grant awarded under this subsection to sup-
2 port the conduct of activities described in the preceding
3 sentence.''.

4 **SEC. 3307. IMPROVING FORMULARY REQUIREMENTS FOR**
5 **PRESCRIPTION DRUG PLANS AND MA–PD**
6 **PLANS WITH RESPECT TO CERTAIN CAT-**
7 **EGORIES OR CLASSES OF DRUGS.**

8 (a) IMPROVING FORMULARY REQUIREMENTS.—Sec-
9 tion 1860D–4(b)(3)(G) of the Social Security Act is
10 amended to read as follows:

11 ''(G) REQUIRED INCLUSION OF DRUGS IN
12 CERTAIN CATEGORIES AND CLASSES.—

13 ''(i) FORMULARY REQUIREMENTS.—

14 ''(I) IN GENERAL.—Subject to
15 subclause (II), a PDP sponsor offer-
16 ing a prescription drug plan shall be
17 required to include all covered part D
18 drugs in the categories and classes
19 identified by the Secretary under
20 clause (ii)(I).

21 ''(II) EXCEPTIONS.—The Sec-
22 retary may establish exceptions that
23 permit a PDP sponsor offering a pre-
24 scription drug plan to exclude from its
25 formulary a particular covered part D

1 drug in a category or class that is
2 otherwise required to be included in
3 the formulary under subclause (I) (or
4 to otherwise limit access to such a
5 drug, including through prior author-
6 ization or utilization management).
7 ''(ii) IDENTIFICATION OF DRUGS IN
8 CERTAIN CATEGORIES AND CLASSES.—
9 ''(I) IN GENERAL.—Subject to
10 clause (iv), the Secretary shall iden-
11 tify, as appropriate, categories and
12 classes of drugs for which the Sec-
13 retary determines are of clinical con-
14 cern.
15 ''(II) CRITERIA.—The Secretary
16 shall use criteria established by the
17 Secretary in making any determina-
18 tion under subclause (I).
19 ''(iii) IMPLEMENTATION.—The Sec-
20 retary shall establish the criteria under
21 clause (ii)(II) and any exceptions under
22 clause (i)(II) through the promulgation of
23 a regulation which includes a public notice
24 and comment period.

"(iv) REQUIREMENT FOR CERTAIN CATEGORIES AND CLASSES UNTIL CRITERIA ESTABLISHED.—Until such time as the Secretary establishes the criteria under clause (ii)(II) the following categories and classes of drugs shall be identified under clause (ii)(I):

"(I) Anticonvulsants.

"(II) Antidepressants.

"(III) Antineoplastics.

"(IV) Antipsychotics.

"(V) Antiretrovirals.

"(VI) Immunosuppressants for the treatment of transplant rejection.".

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to plan year 2011 and subsequent plan years.

SEC. 3308. REDUCING PART D PREMIUM SUBSIDY FOR HIGH-INCOME BENEFICIARIES.

(a) INCOME-RELATED INCREASE IN PART D PREMIUM.—

(1) IN GENERAL.—Section 1860D–13(a) of the Social Security Act (42 U.S.C. 1395w–113(a)) is

amended by adding at the end the following new paragraph:

"(7) INCREASE IN BASE BENEFICIARY PREMIUM BASED ON INCOME.—

"(A) IN GENERAL.—In the case of an individual whose modified adjusted gross income exceeds the threshold amount applicable under paragraph (2) of section 1839(i) (including application of paragraph (5) of such section) for the calendar year, the monthly amount of the beneficiary premium applicable under this section for a month after December 2010 shall be increased by the monthly adjustment amount specified in subparagraph (B).

"(B) MONTHLY ADJUSTMENT AMOUNT.—The monthly adjustment amount specified in this subparagraph for an individual for a month in a year is equal to the product of—

"(i) the quotient obtained by dividing—

"(I) the applicable percentage determined under paragraph (3)(C) of section 1839(i) (including application of paragraph (5) of such section) for

the individual for the calendar year reduced by 25.5 percent; by

"(II) 25.5 percent; and

"(ii) the base beneficiary premium (as computed under paragraph (2)).

"(C) MODIFIED ADJUSTED GROSS INCOME.—For purposes of this paragraph, the term 'modified adjusted gross income' has the meaning given such term in subparagraph (A) of section 1839(i)(4), determined for the taxable year applicable under subparagraphs (B) and (C) of such section.

"(D) DETERMINATION BY COMMISSIONER OF SOCIAL SECURITY.—The Commissioner of Social Security shall make any determination necessary to carry out the income-related increase in the base beneficiary premium under this paragraph.

"(E) PROCEDURES TO ASSURE CORRECT INCOME-RELATED INCREASE IN BASE BENEFICIARY PREMIUM.—

"(i) DISCLOSURE OF BASE BENEFICIARY PREMIUM.—Not later than September 15 of each year beginning with 2010, the Secretary shall disclose to the

Commissioner of Social Security the amount of the base beneficiary premium (as computed under paragraph (2)) for the purpose of carrying out the income-related increase in the base beneficiary premium under this paragraph with respect to the following year.

"(ii) ADDITIONAL DISCLOSURE.—Not later than October 15 of each year beginning with 2010, the Secretary shall disclose to the Commissioner of Social Security the following information for the purpose of carrying out the income-related increase in the base beneficiary premium under this paragraph with respect to the following year:

"(I) The modified adjusted gross income threshold applicable under paragraph (2) of section 1839(i) (including application of paragraph (5) of such section).

"(II) The applicable percentage determined under paragraph (3)(C) of section 1839(i) (including application of paragraph (5) of such section).

"(III) The monthly adjustment amount specified in subparagraph (B).

"(IV) Any other information the Commissioner of Social Security determines necessary to carry out the income-related increase in the base beneficiary premium under this paragraph.

"(F) RULE OF CONSTRUCTION.—The formula used to determine the monthly adjustment amount specified under subparagraph (B) shall only be used for the purpose of determining such monthly adjustment amount under such subparagraph.".

(2) COLLECTION OF MONTHLY ADJUSTMENT AMOUNT.—Section 1860D–13(c) of the Social Security Act (42 U.S.C. 1395w–113(c)) is amended—

(A) in paragraph (1), by striking "(2) and (3)" and inserting "(2), (3), and (4)"; and

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

"(4) COLLECTION OF MONTHLY ADJUSTMENT AMOUNT.—

"(A) IN GENERAL.—Notwithstanding any provision of this subsection or section 1854(d)(2), subject to subparagraph (B), the amount of the income-related increase in the base beneficiary premium for an individual for a month (as determined under subsection (a)(7)) shall be paid through withholding from benefit payments in the manner provided under section 1840.

"(B) AGREEMENTS.—In the case where the monthly benefit payments of an individual that are withheld under subparagraph (A) are insufficient to pay the amount described in such subparagraph, the Commissioner of Social Security shall enter into agreements with the Secretary, the Director of the Office of Personnel Management, and the Railroad Retirement Board as necessary in order to allow other agencies to collect the amount described in subparagraph (A) that was not withheld under such subparagraph.".

(b) CONFORMING AMENDMENTS.—

(1) MEDICARE.—Section 1860D–13(a)(1) of the Social Security Act (42 U.S.C. 1395w–113(a)(1)) is amended—

(A) by redesignating subparagraph (F) as subparagraph (G);

(B) in subparagraph (G), as redesignated by subparagraph (A), by striking ''(D) and (E)'' and inserting ''(D), (E), and (F)''; and

(C) by inserting after subparagraph (E) the following new subparagraph:

''(F) INCREASE BASED ON INCOME.—The monthly beneficiary premium shall be increased pursuant to paragraph (7).''.

(2) INTERNAL REVENUE CODE.—Section 6103(l)(20) of the Internal Revenue Code of 1986 (relating to disclosure of return information to carry out Medicare part B premium subsidy adjustment) is amended—

(A) in the heading, by inserting ''AND PART D BASE BENEFICIARY PREMIUM INCREASE'' after ''PART B PREMIUM SUBSIDY ADJUSTMENT'';

(B) in subparagraph (A)—

(i) in the matter preceding clause (i), by inserting ''or increase under section 1860D–13(a)(7)'' after ''1839(i)''; and

(ii) in clause (vii), by inserting after ''subsection (i) of such section'' the fol-

lowing: ''or increase under section 1860D–13(a)(7) of such Act''; and

(C) in subparagraph (B)—

(i) by striking ''Return information'' and inserting the following:

''(i) IN GENERAL.—Return information'';

(ii) by inserting ''or increase under such section 1860D–13(a)(7)'' before the period at the end;

(iii) as amended by clause (i), by inserting ''or for the purpose of resolving taxpayer appeals with respect to any such premium adjustment or increase'' before the period at the end; and

(iv) by adding at the end the following new clause:

''(ii) DISCLOSURE TO OTHER AGENCIES.—Officers, employees, and contractors of the Social Security Administration may disclose—

''(I) the taxpayer identity information and the amount of the premium subsidy adjustment or premium increase with respect to a taxpayer de-

1 scribed in subparagraph (A) to offi-
2 cers, employees, and contractors of
3 the Centers for Medicare and Med-
4 icaid Services, to the extent that such
5 disclosure is necessary for the collec-
6 tion of the premium subsidy amount
7 or the increased premium amount,
8 ''(II) the taxpayer identity infor-
9 mation and the amount of the pre-
10 mium subsidy adjustment or the in-
11 creased premium amount with respect
12 to a taxpayer described in subpara-
13 graph (A) to officers and employees of
14 the Office of Personnel Management
15 and the Railroad Retirement Board,
16 to the extent that such disclosure is
17 necessary for the collection of the pre-
18 mium subsidy amount or the in-
19 creased premium amount,
20 ''(III) return information with re-
21 spect to a taxpayer described in sub-
22 paragraph (A) to officers and employ-
23 ees of the Department of Health and
24 Human Services to the extent nec-
25 essary to resolve administrative ap-

peals of such premium subsidy adjustment or increased premium, and

"(IV) return information with respect to a taxpayer described in subparagraph (A) to officers and employees of the Department of Justice for use in judicial proceedings to the extent necessary to carry out the purposes described in clause (i).".

SEC. 3309. ELIMINATION OF COST SHARING FOR CERTAIN DUAL ELIGIBLE INDIVIDUALS.

Section 1860D–14(a)(1)(D)(i) of the Social Security Act (42 U.S.C. 1395w–114(a)(1)(D)(i)) is amended by inserting "or, effective on a date specified by the Secretary (but in no case earlier than January 1, 2012), who would be such an institutionalized individual or couple, if the full-benefit dual eligible individual were not receiving services under a home and community-based waiver authorized for a State under section 1115 or subsection (c) or (d) of section 1915 or under a State plan amendment under subsection (i) of such section or services provided through enrollment in a medicaid managed care organization with a contract under section 1903(m) or under section 1932" after "1902(q)(1)(B))".

SEC. 3310. REDUCING WASTEFUL DISPENSING OF OUTPATIENT PRESCRIPTION DRUGS IN LONG-TERM CARE FACILITIES UNDER PRESCRIPTION DRUG PLANS AND MA–PD PLANS.

(a) IN GENERAL.—Section 1860D–4(c) of the Social Security Act (42 U.S.C. 1395w–104(c)) is amended by adding at the end the following new paragraph:

"(3) REDUCING WASTEFUL DISPENSING OF OUTPATIENT PRESCRIPTION DRUGS IN LONG-TERM CARE FACILITIES.—The Secretary shall require PDP sponsors of prescription drug plans to utilize specific, uniform dispensing techniques, as determined by the Secretary, in consultation with relevant stakeholders (including representatives of nursing facilities, residents of nursing facilities, pharmacists, the pharmacy industry (including retail and long-term care pharmacy), prescription drug plans, MA–PD plans, and any other stakeholders the Secretary determines appropriate), such as weekly, daily, or automated dose dispensing, when dispensing covered part D drugs to enrollees who reside in a long-term care facility in order to reduce waste associated with 30-day fills.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to plan years beginning on or after January 1, 2012.

SEC. 3311. IMPROVED MEDICARE PRESCRIPTION DRUG PLAN AND MA–PD PLAN COMPLAINT SYSTEM.

(a) IN GENERAL.—The Secretary shall develop and maintain a complaint system, that is widely known and easy to use, to collect and maintain information on MA–PD plan and prescription drug plan complaints that are received (including by telephone, letter, e-mail, or any other means) by the Secretary (including by a regional office of the Department of Health and Human Services, the Medicare Beneficiary Ombudsman, a subcontractor, a carrier, a fiscal intermediary, and a Medicare administrative contractor under section 1874A of the Social Security Act (42 U.S.C. 1395kk)) through the date on which the complaint is resolved. The system shall be able to report and initiate appropriate interventions and monitoring based on substantial complaints and to guide quality improvement.

(b) MODEL ELECTRONIC COMPLAINT FORM.—The Secretary shall develop a model electronic complaint form to be used for reporting plan complaints under the system. Such form shall be prominently displayed on the front page of the Medicare.gov Internet website and on the Internet website of the Medicare Beneficiary Ombudsman.

(c) ANNUAL REPORTS BY THE SECRETARY.—The Secretary shall submit to Congress annual reports on the system. Such reports shall include an analysis of the num-

ber and types of complaints reported in the system, geographic variations in such complaints, the timeliness of agency or plan responses to such complaints, and the resolution of such complaints.

(d) DEFINITIONS.—In this section:

(1) MA–PD PLAN.—The term ''MA–PD plan'' has the meaning given such term in section 1860D–41(a)(9) of such Act (42 U.S.C. 1395w–151(a)(9)).

(2) PRESCRIPTION DRUG PLAN.—The term ''prescription drug plan'' has the meaning given such term in section 1860D–41(a)(14) of such Act (42 U.S.C. 1395w–151(a)(14)).

(3) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(4) SYSTEM.—The term ''system'' means the plan complaint system developed and maintained under subsection (a).

SEC. 3312. UNIFORM EXCEPTIONS AND APPEALS PROCESS FOR PRESCRIPTION DRUG PLANS AND MA–PD PLANS.

(a) IN GENERAL.—Section 1860D–4(b)(3) of the Social Security Act (42 U.S.C. 1395w–104(b)(3)) is amended by adding at the end the following new subparagraph:

''(H) USE OF SINGLE, UNIFORM EXCEPTIONS AND APPEALS PROCESS.—Notwith-

standing any other provision of this part, each PDP sponsor of a prescription drug plan shall—

"(i) use a single, uniform exceptions and appeals process (including, to the extent the Secretary determines feasible, a single, uniform model form for use under such process) with respect to the determination of prescription drug coverage for an enrollee under the plan; and

"(ii) provide instant access to such process by enrollees through a toll-free telephone number and an Internet website.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to exceptions and appeals on or after January 1, 2012.

SEC. 3313. OFFICE OF THE INSPECTOR GENERAL STUDIES AND REPORTS.

(a) STUDY AND ANNUAL REPORT ON PART D FORMULARIES' INCLUSION OF DRUGS COMMONLY USED BY DUAL ELIGIBLES.—

(1) STUDY.—The Inspector General of the Department of Health and Human Services shall conduct a study of the extent to which formularies used

1 by prescription drug plans and MA–PD plans under
2 part D include drugs commonly used by full-benefit
3 dual eligible individuals (as defined in section
4 1935(c)(6) of the Social Security Act (42 U.S.C.
5 1396u–5(c)(6))).

6 (2) ANNUAL REPORTS.—Not later than July 1
7 of each year (beginning with 2011), the Inspector
8 General shall submit to Congress a report on the
9 study conducted under paragraph (1), together with
10 such recommendations as the Inspector General de-
11 termines appropriate.

12 (b) STUDY AND REPORT ON PRESCRIPTION DRUG
13 PRICES UNDER MEDICARE PART D AND MEDICAID.—

14 (1) STUDY.—

15 (A) IN GENERAL.—The Inspector General
16 of the Department of Health and Human Serv-
17 ices shall conduct a study on prices for covered
18 part D drugs under the Medicare prescription
19 drug program under part D of title XVIII of
20 the Social Security Act and for covered out-
21 patient drugs under title XIX. Such study shall
22 include the following:

23 (i) A comparison, with respect to the
24 200 most frequently dispensed covered
25 part D drugs under such program and cov-

1 ered outpatient drugs under such title (as
2 determined by the Inspector General based
3 on volume and expenditures), of—
4 (I) the prices paid for covered
5 part D drugs by PDP sponsors of
6 prescription drug plans and Medicare
7 Advantage organizations offering MA–
8 PD plans; and
9 (II) the prices paid for covered
10 outpatient drugs by a State plan
11 under title XIX.
12 (ii) An assessment of—
13 (I) the financial impact of any
14 discrepancies in such prices on the
15 Federal Government; and
16 (II) the financial impact of any
17 such discrepancies on enrollees under
18 part D or individuals eligible for med-
19 ical assistance under a State plan
20 under title XIX.
21 (B) PRICE.—For purposes of subpara-
22 graph (A), the price of a covered part D drug
23 or a covered outpatient drug shall include any
24 rebate or discount under such program or such
25 title, respectively, including any negotiated price

concession described in section 1860D–2(d)(1)(B) of the Social Security Act (42 U.S.C. 1395w–102(d)(1)(B)) or rebate under an agreement under section 1927 of the Social Security Act (42 U.S.C. 1396r–8).

(C) AUTHORITY TO COLLECT ANY NECESSARY INFORMATION.—Notwithstanding any other provision of law, the Inspector General of the Department of Health and Human Services shall be able to collect any information related to the prices of covered part D drugs under such program and covered outpatient drugs under such title XIX necessary to carry out the comparison under subparagraph (A).

(2) REPORT.—

(A) IN GENERAL.—Not later than October 1, 2011, subject to subparagraph (B), the Inspector General shall submit to Congress a report containing the results of the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Inspector General determines appropriate.

(B) LIMITATION ON INFORMATION CONTAINED IN REPORT.—The report submitted

under subparagraph (A) shall not include any information that the Inspector General determines is proprietary or is likely to negatively impact the ability of a PDP sponsor or a State plan under title XIX to negotiate prices for covered part D drugs or covered outpatient drugs, respectively.

(3) DEFINITIONS.—In this section:

(A) COVERED PART D DRUG.—The term ''covered part D drug'' has the meaning given such term in section 1860D–2(e) of the Social Security Act (42 U.S.C. 1395w–102(e)).

(B) COVERED OUTPATIENT DRUG.—The term ''covered outpatient drug'' has the meaning given such term in section 1927(k) of such Act (42 U.S.C. 1396r(k)).

(C) MA–PD PLAN.—The term ''MA–PD plan'' has the meaning given such term in section 1860D–41(a)(9) of such Act (42 U.S.C. 1395w–151(a)(9)).

(D) MEDICARE ADVANTAGE ORGANIZATION.—The term ''Medicare Advantage organization'' has the meaning given such term in section 1859(a)(1) of such Act (42 U.S.C. 1395w–28)(a)(1)).

(E) PDP SPONSOR.—The term ''PDP sponsor'' has the meaning given such term in section 1860D–41(a)(13) of such Act (42 U.S.C. 1395w–151(a)(13)).

(F) PRESCRIPTION DRUG PLAN.—The term ''prescription drug plan'' has the meaning given such term in section 1860D–41(a)(14) of such Act (42 U.S.C. 1395w–151(a)(14)).

SEC. 3314. INCLUDING COSTS INCURRED BY AIDS DRUG ASSISTANCE PROGRAMS AND INDIAN HEALTH SERVICE IN PROVIDING PRESCRIPTION DRUGS TOWARD THE ANNUAL OUT-OF-POCKET THRESHOLD UNDER PART D.

(a) IN GENERAL.—Section 1860D–2(b)(4)(C) of the Social Security Act (42 U.S.C. 1395w–102(b)(4)(C)) is amended—

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

(2) in clause (ii)—

(A) by striking ''such costs shall be treated as incurred only if'' and inserting ''subject to clause (iii), such costs shall be treated as incurred only if'';

(B) by striking '', under section 1860D–14, or under a State Pharmaceutical Assistance Program''; and

(C) by striking the period at the end and inserting "; and"; and

(3) by inserting after clause (ii) the following new clause:

"(iii) such costs shall be treated as incurred and shall not be considered to be reimbursed under clause (ii) if such costs are borne or paid—

"(I) under section 1860D–14;

"(II) under a State Pharmaceutical Assistance Program;

"(III) by the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization (as defined in section 4 of the Indian Health Care Improvement Act); or

"(IV) under an AIDS Drug Assistance Program under part B of title XXVI of the Public Health Service Act.".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to costs incurred on or after January 1, 2011.

SEC. 3315. IMMEDIATE REDUCTION IN COVERAGE GAP IN 2010.

Section 1860D–2(b) of the Social Security Act (42 U.S.C. 1395w–102(b)) is amended—

(1) in paragraph (3)(A), by striking ''paragraph (4)'' and inserting ''paragraphs (4) and (7)''; and

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

''(7) INCREASE IN INITIAL COVERAGE LIMIT IN 2010.—

''(A) IN GENERAL.—For the plan year beginning on January 1, 2010, the initial coverage limit described in paragraph (3)(B) otherwise applicable shall be increased by $500.

''(B) APPLICATION.—In applying subparagraph (A)—

''(i) except as otherwise provided in this subparagraph, there shall be no change in the premiums, bids, or any other parameters under this part or part C;

''(ii) costs that would be treated as incurred costs for purposes of applying paragraph (4) but for the application of subparagraph (A) shall continue to be treated as incurred costs;

1 "(iii) the Secretary shall establish pro-
2 cedures, which may include a reconciliation
3 process, to fully reimburse PDP sponsors
4 with respect to prescription drug plans and
5 MA organizations with respect to MA–PD
6 plans for the reduction in beneficiary cost
7 sharing associated with the application of
8 subparagraph (A);
9 "(iv) the Secretary shall develop an
10 estimate of the additional increased costs
11 attributable to the application of this para-
12 graph for increased drug utilization and fi-
13 nancing and administrative costs and shall
14 use such estimate to adjust payments to
15 PDP sponsors with respect to prescription
16 drug plans under this part and MA organi-
17 zations with respect to MA–PD plans
18 under part C; and
19 "(v) the Secretary shall establish pro-
20 cedures for retroactive reimbursement of
21 part D eligible individuals who are covered
22 under such a plan for costs which are in-
23 curred before the date of initial implemen-
24 tation of subparagraph (A) and which
25 would be reimbursed under such a plan if

such implementation occurred as of January 1, 2010.

"(C) NO EFFECT ON SUBSEQUENT YEARS.—The increase under subparagraph (A) shall only apply with respect to the plan year beginning on January 1, 2010, and the initial coverage limit for plan years beginning on or after January 1, 2011, shall be determined as if subparagraph (A) had never applied.".

Subtitle E—Ensuring Medicare Sustainability

SEC. 3401. REVISION OF CERTAIN MARKET BASKET UPDATES AND INCORPORATION OF PRODUCTIVITY IMPROVEMENTS INTO MARKET BASKET UPDATES THAT DO NOT ALREADY INCORPORATE SUCH IMPROVEMENTS.

(a) INPATIENT ACUTE HOSPITALS.—Section 1886(b)(3)(B) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)), as amended by section 3001(a)(3), is further amended—

(1) in clause (i)(XX), by striking "clause (viii)" and inserting "clauses (viii), (ix), (xi), and (xii)";

(2) in the first sentence of clause (viii), by inserting "of such applicable percentage increase (de-

1 termined without regard to clause (ix), (xi), or
2 (xii))'' after ''one-quarter'';
3 (3) in the first sentence of clause (ix)(I), by in-
4 serting ''(determined without regard to clause (viii),
5 (xi), or (xii))'' after ''clause (i)'' the second time it
6 appears; and
7 (4) by adding at the end the following new
8 clauses:
9 ''(xi)(I) For 2012 and each subsequent fiscal year,
10 after determining the applicable percentage increase de-
11 scribed in clause (i) and after application of clauses (viii)
12 and (ix), such percentage increase shall be reduced by the
13 productivity adjustment described in subclause (II).
14 ''(II) The productivity adjustment described in this
15 subclause, with respect to a percentage, factor, or update
16 for a fiscal year, year, cost reporting period, or other an-
17 nual period, is a productivity adjustment equal to the 10-
18 year moving average of changes in annual economy-wide
19 private nonfarm business multi-factor productivity (as
20 projected by the Secretary for the 10-year period ending
21 with the applicable fiscal year, year, cost reporting period,
22 or other annual period).
23 ''(III) The application of subclause (I) may result in
24 the applicable percentage increase described in clause (i)
25 being less than 0.0 for a fiscal year, and may result in

payment rates under this section for a fiscal year being less than such payment rates for the preceding fiscal year.

"(xii) After determining the applicable percentage increase described in clause (i), and after application of clauses (viii), (ix), and (xi), the Secretary shall reduce such applicable percentage increase—

"(I) for each of fiscal years 2010 and 2011, by 0.25 percentage point; and

"(II) subject to clause (xiii), for each of fiscal years 2012 through 2019, by 0.2 percentage point.

The application of this clause may result in the applicable percentage increase described in clause (i) being less than 0.0 for a fiscal year, and may result in payment rates under this section for a fiscal year being less than such payment rates for the preceding fiscal year.

"(xiii) Clause (xii) shall be applied with respect to any of fiscal years 2014 through 2019 by substituting '0.0 percentage points' for '0.2 percentage point', if for such fiscal year—

"(I) the excess (if any) of—

"(aa) the total percentage of the non-elderly insured population for the preceding fiscal year (based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on

the Patient Protection and Affordable Care Act that, if determined in the affirmative, would clear such Act for enrollment); over

"(bb) the total percentage of the non-elderly insured population for such preceding fiscal year (as estimated by the Secretary); exceeds

"(II) 5 percentage points.".

(b) SKILLED NURSING FACILITIES.—Section 1888(e)(5)(B) of the Social Security Act (42 U.S.C. 1395yy(e)(5)(B)) is amended—

(1) by striking "PERCENTAGE.—The term" and inserting "PERCENTAGE.—

"(i) IN GENERAL.—Subject to clause (ii), the term"; and

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

"(ii) ADJUSTMENT.—For fiscal year 2012 and each subsequent fiscal year, after determining the percentage described in clause (i), the Secretary shall reduce such percentage by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II). The application of the preceding sentence may result in such percentage being less than 0.0 for a fiscal

1 year, and may result in payment rates
2 under this subsection for a fiscal year
3 being less than such payment rates for the
4 preceding fiscal year.''.
5 (c) LONG-TERM CARE HOSPITALS.—Section 1886(m)
6 of the Social Security Act (42 U.S.C. 1395ww(m)) is
7 amended by adding at the end the following new para-
8 graphs:
9 ''(3) IMPLEMENTATION FOR RATE YEAR 2010
10 AND SUBSEQUENT YEARS.—
11 ''(A) IN GENERAL.—In implementing the
12 system described in paragraph (1) for rate year
13 2010 and each subsequent rate year, any an-
14 nual update to a standard Federal rate for dis-
15 charges for the hospital during the rate year,
16 shall be reduced—
17 ''(i) for rate year 2012 and each sub-
18 sequent rate year, by the productivity ad-
19 justment described in section
20 1886(b)(3)(B)(xi)(II); and
21 ''(ii) for each of rate years 2010
22 through 2019, by the other adjustment de-
23 scribed in paragraph (4).
24 ''(B) SPECIAL RULE.—The application of
25 this paragraph may result in such annual up-

date being less than 0.0 for a rate year, and may result in payment rates under the system described in paragraph (1) for a rate year being less than such payment rates for the preceding rate year.

"(4) OTHER ADJUSTMENT.—

"(A) IN GENERAL.—For purposes of paragraph (3)(A)(ii), the other adjustment described in this paragraph is—

"(i) for each of rate years 2010 and 2011, 0.25 percentage point; and

"(ii) subject to subparagraph (B), for each of rate years 2012 through 2019, 0.2 percentage point.

"(B) REDUCTION OF OTHER ADJUSTMENT.—Subparagraph (A)(ii) shall be applied with respect to any of rate years 2014 through 2019 by substituting '0.0 percentage points' for '0.2 percentage point', if for such rate year—

"(i) the excess (if any) of—

"(I) the total percentage of the non-elderly insured population for the preceding rate year (based on the most recent estimates available from the Director of the Congressional

Budget Office before a vote in either House on the Patient Protection and Affordable Care Act that, if determined in the affirmative, would clear such Act for enrollment); over

"(II) the total percentage of the non-elderly insured population for such preceding rate year (as estimated by the Secretary); exceeds

"(ii) 5 percentage points.".

(d) INPATIENT REHABILITATION FACILITIES.—Section 1886(j)(3) of the Social Security Act (42 U.S.C. 1395ww(j)(3)) is amended—

(1) in subparagraph (C)—

(A) by striking "FACTOR.—For purposes" and inserting "FACTOR.—

"(i) IN GENERAL.—For purposes";

(B) by inserting "subject to clause (ii)" before the period at the end of the first sentence of clause (i), as added by paragraph (1); and

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

"(ii) PRODUCTIVITY AND OTHER ADJUSTMENT.—After establishing the increase factor described in clause (i) for a

fiscal year, the Secretary shall reduce such increase factor—

"(I) for fiscal year 2012 and each subsequent fiscal year, by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II); and

"(II) for each of fiscal years 2010 through 2019, by the other adjustment described in subparagraph (D).

The application of this clause may result in the increase factor under this subparagraph being less than 0.0 for a fiscal year, and may result in payment rates under this subsection for a fiscal year being less than such payment rates for the preceding fiscal year."; and

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

"(D) OTHER ADJUSTMENT.—

"(i) IN GENERAL.—For purposes of subparagraph (C)(ii)(II), the other adjustment described in this subparagraph is—

"(I) for each of fiscal years 2010 and 2011, 0.25 percentage point; and

"(II) subject to clause (ii), for each of fiscal years 2012 through 2019, 0.2 percentage point.

"(ii) REDUCTION OF OTHER ADJUSTMENT.—Clause (i)(II) shall be applied with respect to any of fiscal years 2014 through 2019 by substituting '0.0 percentage points' for '0.2 percentage point', if for such fiscal year—

"(I) the excess (if any) of—

"(aa) the total percentage of the non-elderly insured population for the preceding fiscal year (based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Patient Protection and Affordable Care Act that, if determined in the affirmative, would clear such Act for enrollment); over

"(bb) the total percentage of the non-elderly insured population for such preceding fiscal

1 year (as estimated by the Sec-
2 retary); exceeds
3 ''(II) 5 percentage points.''.
4 (e) HOME HEALTH AGENCIES.—Section
5 1895(b)(3)(B) of the Social Security Act (42 U.S.C.
6 1395fff(b)(3)(B)) is amended—
7 (1) in clause (ii)(V), by striking ''clause (v)''
8 and inserting ''clauses (v) and (vi)''; and
9 (2) by adding at the end the following new
10 clause:
11 ''(vi) ADJUSTMENTS.—After deter-
12 mining the home health market basket per-
13 centage increase under clause (iii), and
14 after application of clause (v), the Sec-
15 retary shall reduce such percentage—
16 ''(I) for 2015 and each subse-
17 quent year, by the productivity adjust-
18 ment described in section
19 1886(b)(3)(B)(xi)(II); and
20 ''(II) for each of 2011 and 2012,
21 by 1 percentage point.
22 The application of this clause may result in
23 the home health market basket percentage
24 increase under clause (iii) being less than
25 0.0 for a year, and may result in payment

rates under the system under this subsection for a year being less than such payment rates for the preceding year.''.

(f) PSYCHIATRIC HOSPITALS.—Section 1886 of the Social Security Act, as amended by sections 3001, 3008, 3025, and 3133, is amended by adding at the end the following new subsection:

''(s) PROSPECTIVE PAYMENT FOR PSYCHIATRIC HOSPITALS.—

''(1) REFERENCE TO ESTABLISHMENT AND IMPLEMENTATION OF SYSTEM.—For provisions related to the establishment and implementation of a prospective payment system for payments under this title for inpatient hospital services furnished by psychiatric hospitals (as described in clause (i) of subsection (d)(1)(B)) and psychiatric units (as described in the matter following clause (v) of such subsection), see section 124 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999.

''(2) IMPLEMENTATION FOR RATE YEAR BEGINNING IN 2010 AND SUBSEQUENT RATE YEARS.—

''(A) IN GENERAL.—In implementing the system described in paragraph (1) for the rate year beginning in 2010 and any subsequent

1 rate year, any update to a base rate for days
2 during the rate year for a psychiatric hospital
3 or unit, respectively, shall be reduced—
4 "(i) for the rate year beginning in
5 2012 and each subsequent rate year, by
6 the productivity adjustment described in
7 section 1886(b)(3)(B)(xi)(II); and
8 "(ii) for each of the rate years begin-
9 ning in 2010 through 2019, by the other
10 adjustment described in paragraph (3).
11 "(B) SPECIAL RULE.—The application of
12 this paragraph may result in such update being
13 less than 0.0 for a rate year, and may result in
14 payment rates under the system described in
15 paragraph (1) for a rate year being less than
16 such payment rates for the preceding rate year.
17 "(3) OTHER ADJUSTMENT.—
18 "(A) IN GENERAL.—For purposes of para-
19 graph (2)(A)(ii), the other adjustment described
20 in this paragraph is—
21 "(i) for each of the rate years begin-
22 ning in 2010 and 2011, 0.25 percentage
23 point; and

"(ii) subject to subparagraph (B), for each of the rate years beginning in 2012 through 2019, 0.2 percentage point.

"(B) REDUCTION OF OTHER ADJUSTMENT.—Subparagraph (A)(ii) shall be applied with respect to any of rate years 2014 through 2019 by substituting '0.0 percentage points' for '0.2 percentage point', if for such rate year—

"(i) the excess (if any) of—

"(I) the total percentage of the non-elderly insured population for the preceding rate year (based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Patient Protection and Affordable Care Act that, if determined in the affirmative, would clear such Act for enrollment); over

"(II) the total percentage of the non-elderly insured population for such preceding rate year (as estimated by the Secretary); exceeds

"(ii) 5 percentage points.".

1 (g) HOSPICE CARE.—Section 1814(i)(1)(C) of the
2 Social Security Act (42 U.S.C. 1395f(i)(1)(C)), as amend-
3 ed by section 3132, is amended by adding at the end the
4 following new clauses:

5 ''(iv) After determining the market basket percentage
6 increase under clause (ii)(VII) or (iii), as applicable, with
7 respect to fiscal year 2013 and each subsequent fiscal
8 year, the Secretary shall reduce such percentage—

9 ''(I) for 2013 and each subsequent fiscal year,
10 by the productivity adjustment described in section
11 1886(b)(3)(B)(xi)(II); and

12 ''(II) subject to clause (v), for each of fiscal
13 years 2013 through 2019, by 0.5 percentage point.
14 The application of this clause may result in the market
15 basket percentage increase under clause (ii)(VII) or (iii),
16 as applicable, being less than 0.0 for a fiscal year, and
17 may result in payment rates under this subsection for a
18 fiscal year being less than such payment rates for the pre-
19 ceding fiscal year.

20 ''(v) Clause (iv)(II) shall be applied with respect to
21 any of fiscal years 2014 through 2019 by substituting '0.0
22 percentage points' for '0.5 percentage point', if for such
23 fiscal year—

24 ''(I) the excess (if any) of—

"(aa) the total percentage of the non-elderly insured population for the preceding fiscal year (based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Patient Protection and Affordable Care Act that, if determined in the affirmative, would clear such Act for enrollment); over

"(bb) the total percentage of the non-elderly insured population for such preceding fiscal year (as estimated by the Secretary); exceeds

"(II) 5 percentage points.".

(h) DIALYSIS.—Section 1881(b)(14)(F) of the Social Security Act (42 U.S.C. 1395rr(b)(14)(F)) is amended—

(1) in clause (i)—

(A) by inserting "(I)" after "(F)(i)"

(B) in subclause (I), as inserted by subparagraph (A)—

(i) by striking "clause (ii)" and inserting "subclause (II) and clause (ii)"; and

(ii) by striking "minus 1.0 percentage point"; and

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

"(II) For 2012 and each subsequent year, after determining the increase factor described in subclause (I), the Secretary shall reduce such increase factor by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II). The application of the preceding sentence may result in such increase factor being less than 0.0 for a year, and may result in payment rates under the payment system under this paragraph for a year being less than such payment rates for the preceding year."; and

(2) in clause (ii)(II)—

(A) by striking "The" and inserting "Subject to clause (i)(II), the"; and

(B) by striking "clause (i) minus 1.0 percentage point" and inserting "clause (i)(I)".

(i) OUTPATIENT HOSPITALS.—Section 1833(t)(3) of the Social Security Act (42 U.S.C. 1395l(t)(3)) is amended—

(1) in subparagraph (C)(iv), by inserting "and subparagraph (F) of this paragraph" after "(17)"; and

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

"(F) PRODUCTIVITY AND OTHER ADJUSTMENT.—After determining the OPD fee schedule increase factor under subparagraph (C)(iv),

the Secretary shall reduce such increase factor—

"(i) for 2012 and subsequent years, by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II); and

"(ii) for each of 2010 through 2019, by the adjustment described in subparagraph (G).

The application of this subparagraph may result in the increase factor under subparagraph (C)(iv) being less than 0.0 for a year, and may result in payment rates under the payment system under this subsection for a year being less than such payment rates for the preceding year.

"(G) OTHER ADJUSTMENT.—

"(i) ADJUSTMENT.—For purposes of subparagraph (F)(ii), the adjustment described in this subparagraph is—

"(I) for each of 2010 and 2011, 0.25 percentage point; and

"(II) subject to clause (ii), for each of 2012 through 2019, 0.2 percentage point.

"(ii) REDUCTION OF OTHER ADJUSTMENT.—Clause (i)(II) shall be applied with

respect to any of 2014 through 2019 by substituting '0.0 percentage points' for '0.2 percentage point', if for such year—

"(I) the excess (if any) of—

"(aa) the total percentage of the non-elderly insured population for the preceding year (based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Patient Protection and Affordable Care Act that, if determined in the affirmative, would clear such Act for enrollment); over

"(bb) the total percentage of the non-elderly insured population for such preceding year (as estimated by the Secretary); exceeds

"(II) 5 percentage points.".

(j) AMBULANCE SERVICES.—Section 1834(l)(3) of the Social Security Act (42 U.S.C. 1395m(l)(3)) is amended—

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

(2) in subparagraph (B)—

(A) by inserting '', subject to subparagraph (C) and the succeeding sentence of this paragraph,'' after ''increased''; and

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

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

''(C) for 2011 and each subsequent year, after determining the percentage increase under subparagraph (B) for the year, reduce such percentage increase by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II).''; and

(4) by adding at the end the following flush sentence:

''The application of subparagraph (C) may result in the percentage increase under subparagraph (B) being less than 0.0 for a year, and may result in payment rates under the fee schedule under this subsection for a year being less than such payment rates for the preceding year.''.

(k) AMBULATORY SURGICAL CENTER SERVICES.—Section 1833(i)(2)(D) of the Social Security Act (42 U.S.C. 1395l(i)(2)(D)) is amended—

(1) by redesignating clause (v) as clause (vi); and

(2) by inserting after clause (iv) the following new clause:

"(v) In implementing the system described in clause (i) for 2011 and each subsequent year, any annual update under such system for the year, after application of clause (iv), shall be reduced by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II). The application of the preceding sentence may result in such update being less than 0.0 for a year, and may result in payment rates under the system described in clause (i) for a year being less than such payment rates for the preceding year.".

(l) LABORATORY SERVICES.—Section 1833(h)(2)(A) of the Social Security Act (42 U.S.C. 1395l(h)(2)(A)) is amended—

(1) in clause (i)—

(A) by inserting ", subject to clause (iv)," after "year) by"; and

(B) by striking "through 2013" and inserting "and 2010"; and

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

"(iv) After determining the adjustment to the fee schedules under clause (i), the Secretary shall reduce such adjustment—

"(I) for 2011 and each subsequent year, by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II); and

"(II) for each of 2011 through 2015, by 1.75 percentage points.

Subclause (I) shall not apply in a year where the adjustment to the fee schedules determined under clause (i) is 0.0 or a percentage decrease for a year. The application of the productivity adjustment under subclause (I) shall not result in an adjustment to the fee schedules under clause (i) being less than 0.0 for a year. The application of subclause (II) may result in an ad-

justment to the fee schedules under clause (i) being less than 0.0 for a year, and may result in payment rates for a year being less than such payment rates for the preceding year.''.

(m) CERTAIN DURABLE MEDICAL EQUIPMENT.—Section 1834(a)(14) of the Social Security Act (42 U.S.C. 1395m(a)(14)) is amended—

(1) in subparagraph (K)—

(A) by striking ''2011, 2012, and 2013,''; and

(B) by inserting ''and'' after the semicolon at the end;

(2) by striking subparagraphs (L) and (M) and inserting the following new subparagraph:

''(L) for 2011 and each subsequent year—

''(i) the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year, reduced by—

''(ii) the productivity adjustment described in section 1886(b)(3)(B)(xi)(II).''; and

(3) by adding at the end the following flush sentence:

"The application of subparagraph (L)(ii) may result in the covered item update under this paragraph being less than 0.0 for a year, and may result in payment rates under this subsection for a year being less than such payment rates for the preceding year.".

(n) PROSTHETIC DEVICES, ORTHOTICS, AND PROSTHETICS.—Section 1834(h)(4) of the Social Security Act (42 U.S.C. 1395m(h)(4)) is amended—

(1) in subparagraph (A)—

(A) in clause (ix), by striking "and" at the end;

(B) in clause (x)—

(i) by striking "a subsequent year" and inserting "for each of 2007 through 2010"; and

(ii) by inserting "and" after the semicolon at the end;

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

"(xi) for 2011 and each subsequent year—

"(I) the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year, reduced by—

"(II) the productivity adjustment described in section 1886(b)(3)(B)(xi)(II)."; and

(D) by adding at the end the following flush sentence:

"The application of subparagraph (A)(xi)(II) may result in the applicable percentage increase under subparagraph (A) being less than 0.0 for a year, and may result in payment rates under this subsection for a year being less than such payment rates for the preceding year.".

(o) OTHER ITEMS.—Section 1842(s)(1) of the Social Security Act (42 U.S.C. 1395u(s)(1)) is amended—

(1) in the first sentence, by striking "Subject to" and inserting "(A) Subject to";

(2) by striking the second sentence and inserting the following new subparagraph:

1 "(B) Any fee schedule established under
2 this paragraph for such item or service shall be
3 updated—
4 "(i) for years before 2011—
5 "(I) subject to subclause (II), by
6 the percentage increase in the con-
7 sumer price index for all urban con-
8 sumers (United States city average)
9 for the 12-month period ending with
10 June of the preceding year; and
11 "(II) for items and services de-
12 scribed in paragraph (2)(D) for 2009,
13 section 1834(a)(14)(J) shall apply
14 under this paragraph instead of the
15 percentage increase otherwise applica-
16 ble; and
17 "(ii) for 2011 and subsequent years—
18 "(I) the percentage increase in
19 the consumer price index for all urban
20 consumers (United States city aver-
21 age) for the 12-month period ending
22 with June of the previous year, re-
23 duced by—

"(II) the productivity adjustment described in section 1886(b)(3)(B)(xi)(II)."; and

(3) by adding at the end the following flush sentence:

"The application of subparagraph (B)(ii)(II) may result in the update under this paragraph being less than 0.0 for a year, and may result in payment rates under any fee schedule established under this paragraph for a year being less than such payment rates for the preceding year.".

(p) NO APPLICATION PRIOR TO APRIL 1, 2010.—Notwithstanding the preceding provisions of this section, the amendments made by subsections (a), (c), and (d) shall not apply to discharges occurring before April 1, 2010.

SEC. 3402. TEMPORARY ADJUSTMENT TO THE CALCULATION OF PART B PREMIUMS.

Section 1839(i) of the Social Security Act (42 U.S.C. 1395r(i)) is amended—

(1) in paragraph (2), in the matter preceding subparagraph (A), by inserting "subject to paragraph (6)," after "subsection,";

(2) in paragraph (3)(A)(i), by striking "The applicable" and inserting "Subject to paragraph (6), the applicable";

(3) by redesignating paragraph (6) as paragraph (7); and

(4) by inserting after paragraph (5) the following new paragraph:

"(6) TEMPORARY ADJUSTMENT TO INCOME THRESHOLDS.—Notwithstanding any other provision of this subsection, during the period beginning on January 1, 2011, and ending on December 31, 2019—

"(A) the threshold amount otherwise applicable under paragraph (2) shall be equal to such amount for 2010; and

"(B) the dollar amounts otherwise applicable under paragraph (3)(C)(i) shall be equal to such dollar amounts for 2010.".

SEC. 3403. INDEPENDENT MEDICARE ADVISORY BOARD.

(a) BOARD.—

(1) IN GENERAL.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), as amended by section 3022, is amended by adding at the end the following new section:

1 "INDEPENDENT MEDICARE ADVISORY BOARD

2 "SEC. 1899A. (a) ESTABLISHMENT.—There is estab-
3 lished an independent board to be known as the 'Inde-
4 pendent Medicare Advisory Board'.

5 "(b) PURPOSE.—It is the purpose of this section to,
6 in accordance with the following provisions of this section,
7 reduce the per capita rate of growth in Medicare spend-
8 ing—

9 "(1) by requiring the Chief Actuary of the Cen-
10 ters for Medicare & Medicaid Services to determine
11 in each year to which this section applies (in this
12 section referred to as 'a determination year') the
13 projected per capita growth rate under Medicare for
14 the second year following the determination year (in
15 this section referred to as 'an implementation year');

16 "(2) if the projection for the implementation
17 year exceeds the target growth rate for that year, by
18 requiring the Board to develop and submit during
19 the first year following the determination year (in
20 this section referred to as 'a proposal year') a pro-
21 posal containing recommendations to reduce the
22 Medicare per capita growth rate to the extent re-
23 quired by this section; and

"(3) by requiring the Secretary to implement such proposals unless Congress enacts legislation pursuant to this section.

"(c) BOARD PROPOSALS.—

"(1) DEVELOPMENT.—

"(A) IN GENERAL.—The Board shall develop detailed and specific proposals related to the Medicare program in accordance with the succeeding provisions of this section.

"(B) ADVISORY REPORTS.—Beginning January 15, 2014, the Board may develop and submit to Congress advisory reports on matters related to the Medicare program, regardless of whether or not the Board submitted a proposal for such year. Such a report may, for years prior to 2020, include recommendations regarding improvements to payment systems for providers of services and suppliers who are not otherwise subject to the scope of the Board's recommendations in a proposal under this section. Any advisory report submitted under this subparagraph shall not be subject to the rules for congressional consideration under subsection (d).

"(2) PROPOSALS.—

1 "(A) REQUIREMENTS.—Each proposal
2 submitted under this section in a proposal year
3 shall meet each of the following requirements:
4 "(i) If the Chief Actuary of the Cen-
5 ters for Medicare & Medicaid Services has
6 made a determination under paragraph
7 (7)(A) in the determination year, the pro-
8 posal shall include recommendations so
9 that the proposal as a whole (after taking
10 into account recommendations under
11 clause (v)) will result in a net reduction in
12 total Medicare program spending in the
13 implementation year that is at least equal
14 to the applicable savings target established
15 under paragraph (7)(B) for such imple-
16 mentation year. In determining whether a
17 proposal meets the requirement of the pre-
18 ceding sentence, reductions in Medicare
19 program spending during the 3-month pe-
20 riod immediately preceding the implemen-
21 tation year shall be counted to the extent
22 that such reductions are a result of the im-
23 plementation of recommendations con-
24 tained in the proposal for a change in the
25 payment rate for an item or service that

1 was effective during such period pursuant
2 to subsection (e)(2)(A).
3 ''(ii) The proposal shall not include
4 any recommendation to ration health care,
5 raise revenues or Medicare beneficiary pre-
6 miums under section 1818, 1818A, or
7 1839, increase Medicare beneficiary cost-
8 sharing (including deductibles, coinsur-
9 ance, and copayments), or otherwise re-
10 strict benefits or modify eligibility criteria.
11 ''(iii) In the case of proposals sub-
12 mitted prior to December 31, 2018, the
13 proposal shall not include any rec-
14 ommendation that would reduce payment
15 rates for items and services furnished,
16 prior to December 31, 2019, by providers
17 of services (as defined in section 1861(u))
18 and suppliers (as defined in section
19 1861(d)) scheduled, pursuant to the
20 amendments made by section 3401 of the
21 Patient Protection and Affordable Care
22 Act, to receive a reduction to the infla-
23 tionary payment updates of such providers
24 of services and suppliers in excess of a re-
25 duction due to productivity in a year in

which such recommendations would take effect.

"(iv) As appropriate, the proposal shall include recommendations to reduce Medicare payments under parts C and D, such as reductions in direct subsidy payments to Medicare Advantage and prescription drug plans specified under paragraph (1) and (2) of section 1860D–15(a) that are related to administrative expenses (including profits) for basic coverage, denying high bids or removing high bids for prescription drug coverage from the calculation of the national average monthly bid amount under section 1860D–13(a)(4), and reductions in payments to Medicare Advantage plans under clauses (i) and (ii) of section 1853(a)(1)(B) that are related to administrative expenses (including profits) and performance bonuses for Medicare Advantage plans under section 1853(n). Any such recommendation shall not affect the base beneficiary premium percentage specified under 1860D–13(a).

1 "(v) The proposal shall include rec-
2 ommendations with respect to administra-
3 tive funding for the Secretary to carry out
4 the recommendations contained in the pro-
5 posal.
6 "(vi) The proposal shall only include
7 recommendations related to the Medicare
8 program.
9 "(B) ADDITIONAL CONSIDERATIONS.—In
10 developing and submitting each proposal under
11 this section in a proposal year, the Board shall,
12 to the extent feasible—
13 "(i) give priority to recommendations
14 that extend Medicare solvency;
15 "(ii) include recommendations that—
16 "(I) improve the health care de-
17 livery system and health outcomes, in-
18 cluding by promoting integrated care,
19 care coordination, prevention and
20 wellness, and quality and efficiency
21 improvement; and
22 "(II) protect and improve Medi-
23 care beneficiaries' access to necessary
24 and evidence-based items and services,
25 including in rural and frontier areas;

1 "(iii) include recommendations that
2 target reductions in Medicare program
3 spending to sources of excess cost growth;
4 "(iv) consider the effects on Medicare
5 beneficiaries of changes in payments to
6 providers of services (as defined in section
7 1861(u)) and suppliers (as defined in sec-
8 tion 1861(d));
9 "(v) consider the effects of the rec-
10 ommendations on providers of services and
11 suppliers with actual or projected negative
12 cost margins or payment updates; and
13 "(vi) consider the unique needs of
14 Medicare beneficiaries who are dually eligi-
15 ble for Medicare and the Medicaid program
16 under title XIX.
17 "(C) NO INCREASE IN TOTAL MEDICARE
18 PROGRAM SPENDING.—Each proposal submitted
19 under this section shall be designed in such a
20 manner that implementation of the rec-
21 ommendations contained in the proposal would
22 not be expected to result, over the 10-year pe-
23 riod starting with the implementation year, in
24 any increase in the total amount of net Medi-
25 care program spending relative to the total

amount of net Medicare program spending that would have occurred absent such implementation.

"(D) CONSULTATION WITH MEDPAC.—The Board shall submit a draft copy of each proposal to be submitted under this section to the Medicare Payment Advisory Commission established under section 1805 for its review. The Board shall submit such draft copy by not later than September 1 of the determination year.

"(E) REVIEW AND COMMENT BY THE SECRETARY.—The Board shall submit a draft copy of each proposal to be submitted to Congress under this section to the Secretary for the Secretary's review and comment. The Board shall submit such draft copy by not later than September 1 of the determination year. Not later than March 1 of the submission year, the Secretary shall submit a report to Congress on the results of such review, unless the Secretary submits a proposal under paragraph (5)(A) in that year.

"(F) CONSULTATIONS.—In carrying out its duties under this section, the Board shall engage in regular consultations with the Med-

1 icaid and CHIP Payment and Access Commis-
2 sion under section 1900.
3 "(3) TRANSMISSION OF BOARD PROPOSAL TO
4 PRESIDENT.—
5 "(A) IN GENERAL.—
6 "(i) IN GENERAL.—Except as pro-
7 vided in clause (ii) and subsection
8 (f)(3)(B), the Board shall transmit a pro-
9 posal under this section to the President
10 on January 15 of each year (beginning
11 with 2014).
12 "(ii) EXCEPTION.—The Board shall
13 not submit a proposal under clause (i) in
14 a proposal year if the year is—
15 "(I) a year for which the Chief
16 Actuary of the Centers for Medicare &
17 Medicaid Services makes a determina-
18 tion in the determination year under
19 paragraph (6)(A) that the growth rate
20 described in clause (i) of such para-
21 graph does not exceed the growth rate
22 described in clause (ii) of such para-
23 graph;
24 "(II) a year in which the Chief
25 Actuary of the Centers for Medicare &

1 Medicaid Services makes a determina-
2 tion in the determination year that
3 the projected percentage increase (if
4 any) for the medical care expenditure
5 category of the Consumer Price Index
6 for All Urban Consumers (United
7 States city average) for the implemen-
8 tation year is less than the projected
9 percentage increase (if any) in the
10 Consumer Price Index for All Urban
11 Consumers (all items; United States
12 city average) for such implementation
13 year; or
14 ''(III) for proposal year 2019 and
15 subsequent proposal years, a year in
16 which the Chief Actuary of the Cen-
17 ters for Medicare & Medicaid Services
18 makes a determination in the deter-
19 mination year that the growth rate
20 described in paragraph (8) exceeds
21 the growth rate described in para-
22 graph (6)(A)(i).
23 ''(iii) START-UP PERIOD.—The Board
24 may not submit a proposal under clause (i)
25 prior to January 15, 2014.

"(B) REQUIRED INFORMATION.—Each proposal submitted by the Board under subparagraph (A)(i) shall include—

"(i) the recommendations described in paragraph (2)(A)(i);

"(ii) an explanation of each recommendation contained in the proposal and the reasons for including such recommendation;

"(iii) an actuarial opinion by the Chief Actuary of the Centers for Medicare & Medicaid Services certifying that the proposal meets the requirements of subparagraphs (A)(i) and (C) of paragraph (2);

"(iv) a legislative proposal that implements the recommendations; and

"(v) other information determined appropriate by the Board.

"(4) PRESIDENTIAL SUBMISSION TO CONGRESS.—Upon receiving a proposal from the Board under paragraph (3)(A)(i) or the Secretary under paragraph (5), the President shall immediately submit such proposal to Congress.

1 "(5) CONTINGENT SECRETARIAL DEVELOP-
2 MENT OF PROPOSAL.—If, with respect to a proposal
3 year, the Board is required, to but fails, to submit
4 a proposal to the President by the deadline applica-
5 ble under paragraph (3)(A)(i), the Secretary shall
6 develop a detailed and specific proposal that satisfies
7 the requirements of subparagraphs (A) and (C)
8 (and, to the extent feasible, subparagraph (B)) of
9 paragraph (2) and contains the information required
10 paragraph (3)(B)). By not later than January 25 of
11 the year, the Secretary shall transmit—
12 "(A) such proposal to the President; and
13 "(B) a copy of such proposal to the Medi-
14 care Payment Advisory Commission for its re-
15 view.
16 "(6) PER CAPITA GROWTH RATE PROJECTIONS
17 BY CHIEF ACTUARY.—
18 "(A) IN GENERAL.—Subject to subsection
19 (f)(3)(A), not later than April 30, 2013, and
20 annually thereafter, the Chief Actuary of the
21 Centers for Medicare & Medicaid Services shall
22 determine in each such year whether—
23 "(i) the projected Medicare per capita
24 growth rate for the implementation year

(as determined under subparagraph (B)); exceeds

"(ii) the projected Medicare per capita target growth rate for the implementation year (as determined under subparagraph (C)).

"(B) MEDICARE PER CAPITA GROWTH RATE.—

"(i) IN GENERAL.—For purposes of this section, the Medicare per capita growth rate for an implementation year shall be calculated as the projected 5-year average (ending with such year) of the growth in Medicare program spending per unduplicated enrollee.

"(ii) REQUIREMENT.—The projection under clause (i) shall—

"(I) to the extent that there is projected to be a negative update to the single conversion factor applicable to payments for physicians' services under section 1848(d) furnished in the proposal year or the implementation year, assume that such update for such services is 0 percent rather

than the negative percent that would otherwise apply; and

"(II) take into account any delivery system reforms or other payment changes that have been enacted or published in final rules but not yet implemented as of the making of such calculation.

"(C) MEDICARE PER CAPITA TARGET GROWTH RATE.—For purposes of this section, the Medicare per capita target growth rate for an implementation year shall be calculated as the projected 5-year average (ending with such year) percentage increase in—

"(i) with respect to a determination year that is prior to 2018, the average of the projected percentage increase (if any) in—

"(I) the Consumer Price Index for All Urban Consumers (all items; United States city average); and

"(II) the medical care expenditure category of the Consumer Price Index for All Urban Consumers (United States city average); and

"(ii) with respect to a determination year that is after 2017, the nominal gross domestic product per capita plus 1.0 percentage point.

"(7) SAVINGS REQUIREMENT.—

"(A) IN GENERAL.—If, with respect to a determination year, the Chief Actuary of the Centers for Medicare & Medicaid Services makes a determination under paragraph (6)(A) that the growth rate described in clause (i) of such paragraph exceeds the growth rate described in clause (ii) of such paragraph, the Chief Actuary shall establish an applicable savings target for the implementation year.

"(B) APPLICABLE SAVINGS TARGET.—For purposes of this section, the applicable savings target for an implementation year shall be an amount equal to the product of—

"(i) the total amount of projected Medicare program spending for the proposal year; and

"(ii) the applicable percent for the implementation year.

"(C) APPLICABLE PERCENT.—For purposes of subparagraph (B), the applicable per-

1 cent for an implementation year is the lesser
2 of—
3 "(i) in the case of—
4 "(I) implementation year 2015,
5 0.5 percent;
6 "(II) implementation year 2016,
7 1.0 percent;
8 "(III) implementation year 2017,
9 1.25 percent; and
10 "(IV) implementation year 2018
11 or any subsequent implementation
12 year, 1.5 percent; and
13 "(ii) the projected excess for the im-
14 plementation year (expressed as a percent)
15 determined under subparagraph (A).
16 "(8) PER CAPITA RATE OF GROWTH IN NA-
17 TIONAL HEALTH EXPENDITURES.—In each deter-
18 mination year (beginning in 2018), the Chief Actu-
19 ary of the Centers for Medicare & Medicaid Services
20 shall project the per capita rate of growth in na-
21 tional health expenditures for the implementation
22 year. Such rate of growth for an implementation
23 year shall be calculated as the projected 5-year aver-
24 age (ending with such year) percentage increase in
25 national health care expenditures.

"(d) CONGRESSIONAL CONSIDERATION.—

"(1) INTRODUCTION.—

"(A) IN GENERAL.—On the day on which a proposal is submitted by the President to the House of Representatives and the Senate under subsection (c)(4), the legislative proposal (described in subsection (c)(3)(B)(iv)) contained in the proposal shall be introduced (by request) in the Senate by the majority leader of the Senate or by Members of the Senate designated by the majority leader of the Senate and shall be introduced (by request) in the House by the majority leader of the House or by Members of the House designated by the majority leader of the House.

"(B) NOT IN SESSION.—If either House is not in session on the day on which such legislative proposal is submitted, the legislative proposal shall be introduced in that House, as provided in subparagraph (A), on the first day thereafter on which that House is in session.

"(C) ANY MEMBER.—If the legislative proposal is not introduced in either House within 5 days on which that House is in session after the day on which the legislative proposal is sub-

1 mitted, then any Member of that House may
2 introduce the legislative proposal.
3 "(D) REFERRAL.—The legislation intro-
4 duced under this paragraph shall be referred by
5 the Presiding Officers of the respective Houses
6 to the Committee on Finance in the Senate and
7 to the Committee on Energy and Commerce
8 and the Committee on Ways and Means in the
9 House of Representatives.
10 "(2) COMMITTEE CONSIDERATION OF PRO-
11 POSAL.—
12 "(A) REPORTING BILL.—Not later than
13 April 1 of any proposal year in which a pro-
14 posal is submitted by the President to Congress
15 under this section, the Committee on Ways and
16 Means and the Committee on Energy and Com-
17 merce of the House of Representatives and the
18 Committee on Finance of the Senate may re-
19 port the bill referred to the Committee under
20 paragraph (1)(D) with committee amendments
21 related to the Medicare program.
22 "(B) CALCULATIONS.—In determining
23 whether a committee amendment meets the re-
24 quirement of subparagraph (A), the reductions
25 in Medicare program spending during the 3-

month period immediately preceding the implementation year shall be counted to the extent that such reductions are a result of the implementation provisions in the committee amendment for a change in the payment rate for an item or service that was effective during such period pursuant to such amendment.

"(C) COMMITTEE JURISDICTION.—Notwithstanding rule XV of the Standing Rules of the Senate, a committee amendment described in subparagraph (A) may include matter not within the jurisdiction of the Committee on Finance if that matter is relevant to a proposal contained in the bill submitted under subsection (c)(3).

"(D) DISCHARGE.—If, with respect to the House involved, the committee has not reported the bill by the date required by subparagraph (A), the committee shall be discharged from further consideration of the proposal.

"(3) LIMITATION ON CHANGES TO THE BOARD RECOMMENDATIONS.—

"(A) IN GENERAL.—It shall not be in order in the Senate or the House of Representatives to consider any bill, resolution, or amend-

ment, pursuant to this subsection or conference report thereon, that fails to satisfy the requirements of subparagraphs (A)(i) and (C) of subsection (c)(2).

"(B) LIMITATION ON CHANGES TO THE BOARD RECOMMENDATIONS IN OTHER LEGISLATION.—It shall not be in order in the Senate or the House of Representatives to consider any bill, resolution, amendment, or conference report (other than pursuant to this section) that would repeal or otherwise change the recommendations of the Board if that change would fail to satisfy the requirements of subparagraphs (A)(i) and (C) of subsection (c)(2).

"(C) LIMITATION ON CHANGES TO THIS SUBSECTION.—It shall not be in order in the Senate or the House of Representatives to consider any bill, resolution, amendment, or conference report that would repeal or otherwise change this subsection.

"(D) WAIVER.—This paragraph may be waived or suspended in the Senate only by the affirmative vote of three-fifths of the Members, duly chosen and sworn.

"(E) APPEALS.—An affirmative vote of three-fifths of the Members of the Senate, duly chosen and sworn, shall be required in the Senate to sustain an appeal of the ruling of the Chair on a point of order raised under this paragraph.

"(4) EXPEDITED PROCEDURE.—

"(A) CONSIDERATION.—A motion to proceed to the consideration of the bill in the Senate is not debatable.

"(B) AMENDMENT.—

"(i) TIME LIMITATION.—Debate in the Senate on any amendment to a bill under this section shall be limited to 1 hour, to be equally divided between, and controlled by, the mover and the manager of the bill, and debate on any amendment to an amendment, debatable motion, or appeal shall be limited to 30 minutes, to be equally divided between, and controlled by, the mover and the manager of the bill, except that in the event the manager of the bill is in favor of any such amendment, motion, or appeal, the time in opposition

thereto shall be controlled by the minority leader or such leader's designee.

"(ii) GERMANE.—No amendment that is not germane to the provisions of such bill shall be received.

"(iii) ADDITIONAL TIME.—The leaders, or either of them, may, from the time under their control on the passage of the bill, allot additional time to any Senator during the consideration of any amendment, debatable motion, or appeal.

"(iv) AMENDMENT NOT IN ORDER.—It shall not be in order to consider an amendment that would cause the bill to result in a net reduction in total Medicare program spending in the implementation year that is less than the applicable savings target established under subsection (c)(7)(B) for such implementation year.

"(v) WAIVER AND APPEALS.—This paragraph may be waived or suspended in the Senate only by the affirmative vote of three-fifths of the Members, duly chosen and sworn. An affirmative vote of three-fifths of the Members of the Senate, duly

chosen and sworn, shall be required in the Senate to sustain an appeal of the ruling of the Chair on a point of order raised under this section.

"(C) CONSIDERATION BY THE OTHER HOUSE.—

"(i) IN GENERAL.—The expedited procedures provided in this subsection for the consideration of a bill introduced pursuant to paragraph (1) shall not apply to such a bill that is received by one House from the other House if such a bill was not introduced in the receiving House.

"(ii) BEFORE PASSAGE.—If a bill that is introduced pursuant to paragraph (1) is received by one House from the other House, after introduction but before disposition of such a bill in the receiving House, then the following shall apply:

"(I) The receiving House shall consider the bill introduced in that House through all stages of consideration up to, but not including, passage.

"(II) The question on passage shall be put on the bill of the other House as amended by the language of the receiving House.

"(iii) AFTER PASSAGE.—If a bill introduced pursuant to paragraph (1) is received by one House from the other House, after such a bill is passed by the receiving House, then the vote on passage of the bill that originates in the receiving House shall be considered to be the vote on passage of the bill received from the other House as amended by the language of the receiving House.

"(iv) DISPOSITION.—Upon disposition of a bill introduced pursuant to paragraph (1) that is received by one House from the other House, it shall no longer be in order to consider the bill that originates in the receiving House.

"(v) LIMITATION.—Clauses (ii), (iii), and (iv) shall apply only to a bill received by one House from the other House if the bill—

"(I) is related only to the program under this title; and

"(II) satisfies the requirements of subparagraphs (A)(i) and (C) of subsection (c)(2).

"(D) SENATE LIMITS ON DEBATE.—

"(i) IN GENERAL.—In the Senate, consideration of the bill and on all debatable motions and appeals in connection therewith shall not exceed a total of 30 hours, which shall be divided equally between the majority and minority leaders or their designees.

"(ii) MOTION TO FURTHER LIMIT DEBATE.—A motion to further limit debate on the bill is in order and is not debatable.

"(iii) MOTION OR APPEAL.—Any debatable motion or appeal is debatable for not to exceed 1 hour, to be divided equally between those favoring and those opposing the motion or appeal.

"(iv) FINAL DISPOSITION.—After 30 hours of consideration, the Senate shall proceed, without any further debate on any question, to vote on the final disposition

thereof to the exclusion of all amendments not then pending before the Senate at that time and to the exclusion of all motions, except a motion to table, or to reconsider and one quorum call on demand to establish the presence of a quorum (and motions required to establish a quorum) immediately before the final vote begins.

''(E) CONSIDERATION IN CONFERENCE.—

''(i) IN GENERAL.—Consideration in the Senate and the House of Representatives on the conference report or any messages between Houses shall be limited to 10 hours, equally divided and controlled by the majority and minority leaders of the Senate or their designees and the Speaker of the House of Representatives and the minority leader of the House of Representatives or their designees.

''(ii) TIME LIMITATION.—Debate in the Senate on any amendment under this subparagraph shall be limited to 1 hour, to be equally divided between, and controlled by, the mover and the manager of the bill, and debate on any amendment to an

amendment, debatable motion, or appeal shall be limited to 30 minutes, to be equally divided between, and controlled by, the mover and the manager of the bill, except that in the event the manager of the bill is in favor of any such amendment, motion, or appeal, the time in opposition thereto shall be controlled by the minority leader or such leader's designee.

''(iii) FINAL DISPOSITION.—After 10 hours of consideration, the Senate shall proceed, without any further debate on any question, to vote on the final disposition thereof to the exclusion of all motions not then pending before the Senate at that time or necessary to resolve the differences between the Houses and to the exclusion of all other motions, except a motion to table, or to reconsider and one quorum call on demand to establish the presence of a quorum (and motions required to establish a quorum) immediately before the final vote begins.

''(iv) LIMITATION.—Clauses (i) through (iii) shall only apply to a con-

ference report, message or the amendments thereto if the conference report, message, or an amendment thereto—

"(I) is related only to the program under this title; and

"(II) satisfies the requirements of subparagraphs (A)(i) and (C) of subsection (c)(2).

"(F) VETO.—If the President vetoes the bill debate on a veto message in the Senate under this subsection shall be 1 hour equally divided between the majority and minority leaders or their designees.

"(5) RULES OF THE SENATE AND HOUSE OF REPRESENTATIVES.—This subsection and subsection (f)(2) are enacted by Congress—

"(A) as an exercise of the rulemaking power of the Senate and the House of Representatives, respectively, and is deemed to be part of the rules of each House, respectively, but applicable only with respect to the procedure to be followed in that House in the case of bill under this section, and it supersedes other rules only to the extent that it is inconsistent with such rules; and

"(B) with full recognition of the constitutional right of either House to change the rules (so far as they relate to the procedure of that House) at any time, in the same manner, and to the same extent as in the case of any other rule of that House.

"(e) IMPLEMENTATION OF PROPOSAL.—

"(1) IN GENERAL.—Notwithstanding any other provision of law, the Secretary shall, except as provided in paragraph (3), implement the recommendations contained in a proposal submitted by the President to Congress pursuant to this section on August 15 of the year in which the proposal is so submitted.

"(2) APPLICATION.—

"(A) IN GENERAL.—A recommendation described in paragraph (1) shall apply as follows:

"(i) In the case of a recommendation that is a change in the payment rate for an item or service under Medicare in which payment rates change on a fiscal year basis (or a cost reporting period basis that relates to a fiscal year), on a calendar year basis (or a cost reporting period basis that relates to a calendar year), or on a rate year basis (or a cost reporting period basis

that relates to a rate year), such recommendation shall apply to items and services furnished on the first day of the first fiscal year, calendar year, or rate year (as the case may be) that begins after such August 15.

"(ii) In the case of a recommendation relating to payments to plans under parts C and D, such recommendation shall apply to plan years beginning on the first day of the first calendar year that begins after such August 15.

"(iii) In the case of any other recommendation, such recommendation shall be addressed in the regular regulatory process timeframe and shall apply as soon as practicable.

"(B) INTERIM FINAL RULEMAKING.—The Secretary may use interim final rulemaking to implement any recommendation described in paragraph (1).

"(3) EXCEPTION.—The Secretary shall not be required to implement the recommendations contained in a proposal submitted in a proposal year by

the President to Congress pursuant to this section if—

"(A) prior to August 15 of the proposal year, Federal legislation is enacted that includes the following provision: 'This Act supercedes the recommendations of the Board contained in the proposal submitted, in the year which includes the date of enactment of this Act, to Congress under section 1899A of the Social Security Act.'; and

"(B) in the case of implementation year 2020 and subsequent implementation years, a joint resolution described in subsection (f)(1) is enacted not later than August 15, 2017.

"(4) NO AFFECT ON AUTHORITY TO IMPLEMENT CERTAIN PROVISIONS.—Nothing in paragraph (3) shall be construed to affect the authority of the Secretary to implement any recommendation contained in a proposal or advisory report under this section to the extent that the Secretary otherwise has the authority to implement such recommendation administratively.

"(5) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the implementa-

1 tion by the Secretary under this subsection of the
2 recommendations contained in a proposal.
3 "(f) JOINT RESOLUTION REQUIRED TO DIS-
4 CONTINUE THE BOARD.—
5 "(1) IN GENERAL.—For purposes of subsection
6 (e)(3)(B), a joint resolution described in this para-
7 graph means only a joint resolution—
8 "(A) that is introduced in 2017 by not
9 later than February 1 of such year;
10 "(B) which does not have a preamble;
11 "(C) the title of which is as follows: 'Joint
12 resolution approving the discontinuation of the
13 process for consideration and automatic imple-
14 mentation of the annual proposal of the Inde-
15 pendent Medicare Advisory Board under section
16 1899A of the Social Security Act'; and
17 "(D) the matter after the resolving clause
18 of which is as follows: 'That Congress approves
19 the discontinuation of the process for consider-
20 ation and automatic implementation of the an-
21 nual proposal of the Independent Medicare Ad-
22 visory Board under section 1899A of the Social
23 Security Act.'.
24 "(2) PROCEDURE.—

"(A) REFERRAL.—A joint resolution described in paragraph (1) shall be referred to the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate.

"(B) DISCHARGE.—In the Senate, if the committee to which is referred a joint resolution described in paragraph (1) has not reported such joint resolution (or an identical joint resolution) at the end of 20 days after the joint resolution described in paragraph (1) is introduced, such committee may be discharged from further consideration of such joint resolution upon a petition supported in writing by 30 Members of the Senate, and such joint resolution shall be placed on the calendar.

"(C) CONSIDERATION.—

"(i) IN GENERAL.—In the Senate, when the committee to which a joint resolution is referred has reported, or when a committee is discharged (under subparagraph (C)) from further consideration of a joint resolution described in paragraph (1), it is at any time thereafter in order (even

1 though a previous motion to the same ef-
2 fect has been disagreed to) for a motion to
3 proceed to the consideration of the joint
4 resolution to be made, and all points of
5 order against the joint resolution (and
6 against consideration of the joint resolu-
7 tion) are waived, except for points of order
8 under the Congressional Budget act of
9 1974 or under budget resolutions pursuant
10 to that Act. The motion is not debatable.
11 A motion to reconsider the vote by which
12 the motion is agreed to or disagreed to
13 shall not be in order. If a motion to pro-
14 ceed to the consideration of the joint reso-
15 lution is agreed to, the joint resolution
16 shall remain the unfinished business of the
17 Senate until disposed of.
18 "(ii) DEBATE LIMITATION.—In the
19 Senate, consideration of the joint resolu-
20 tion, and on all debatable motions and ap-
21 peals in connection therewith, shall be lim-
22 ited to not more than 10 hours, which
23 shall be divided equally between the major-
24 ity leader and the minority leader, or their
25 designees. A motion further to limit debate

is in order and not debatable. An amendment to, or a motion to postpone, or a motion to proceed to the consideration of other business, or a motion to recommit the joint resolution is not in order.

"(iii) PASSAGE.—In the Senate, immediately following the conclusion of the debate on a joint resolution described in paragraph (1), and a single quorum call at the conclusion of the debate if requested in accordance with the rules of the Senate, the vote on passage of the joint resolution shall occur.

"(iv) APPEALS.—Appeals from the decisions of the Chair relating to the application of the rules of the Senate to the procedure relating to a joint resolution described in paragraph (1) shall be decided without debate.

"(D) OTHER HOUSE ACTS FIRST.—If, before the passage by 1 House of a joint resolution of that House described in paragraph (1), that House receives from the other House a joint resolution described in paragraph (1), then the following procedures shall apply:

"(i) The joint resolution of the other House shall not be referred to a committee.

"(ii) With respect to a joint resolution described in paragraph (1) of the House receiving the joint resolution—

"(I) the procedure in that House shall be the same as if no joint resolution had been received from the other House; but

"(II) the vote on final passage shall be on the joint resolution of the other House.

"(E) EXCLUDED DAYS.—For purposes of determining the period specified in subparagraph (B), there shall be excluded any days either House of Congress is adjourned for more than 3 days during a session of Congress.

"(F) MAJORITY REQUIRED FOR ADOPTION.—A joint resolution considered under this subsection shall require an affirmative vote of three-fifths of the Members, duly chosen and sworn, for adoption.

1 "(3) TERMINATION.—If a joint resolution de-
2 scribed in paragraph (1) is enacted not later than
3 August 15, 2017—
4 "(A) the Chief Actuary of the Medicare &
5 Medicaid Services shall not—
6 "(i) make any determinations under
7 subsection (c)(6) after May 1, 2017; or
8 "(ii) provide any opinion pursuant to
9 subsection (c)(3)(B)(iii) after January 16,
10 2018;
11 "(B) the Board shall not submit any pro-
12 posals or advisory reports to Congress under
13 this section after January 16, 2018; and
14 "(C) the Board and the consumer advisory
15 council under subsection (k) shall terminate on
16 August 16, 2018.
17 "(g) BOARD MEMBERSHIP; TERMS OF OFFICE;
18 CHAIRPERSON; REMOVAL.—
19 "(1) MEMBERSHIP.—
20 "(A) IN GENERAL.—The Board shall be
21 composed of—
22 "(i) 15 members appointed by the
23 President, by and with the advice and con-
24 sent of the Senate; and

1 "(ii) the Secretary, the Administrator
2 of the Center for Medicare & Medicaid
3 Services, and the Administrator of the
4 Health Resources and Services Administra-
5 tion, all of whom shall serve ex officio as
6 nonvoting members of the Board.
7 "(B) QUALIFICATIONS.—
8 "(i) IN GENERAL.—The appointed
9 membership of the Board shall include in-
10 dividuals with national recognition for
11 their expertise in health finance and eco-
12 nomics, actuarial science, health facility
13 management, health plans and integrated
14 delivery systems, reimbursement of health
15 facilities, allopathic and osteopathic physi-
16 cians, and other providers of health serv-
17 ices, and other related fields, who provide
18 a mix of different professionals, broad geo-
19 graphic representation, and a balance be-
20 tween urban and rural representatives.
21 "(ii) INCLUSION.—The appointed
22 membership of the Board shall include
23 (but not be limited to) physicians and
24 other health professionals, experts in the
25 area of pharmaco-economics or prescrip-

1 tion drug benefit programs, employers,
2 third-party payers, individuals skilled in
3 the conduct and interpretation of bio-
4 medical, health services, and health eco-
5 nomics research and expertise in outcomes
6 and effectiveness research and technology
7 assessment. Such membership shall also
8 include representatives of consumers and
9 the elderly.

10 ''(iii) MAJORITY NONPROVIDERS.—In-
11 dividuals who are directly involved in the
12 provision or management of the delivery of
13 items and services covered under this title
14 shall not constitute a majority of the ap-
15 pointed membership of the Board.

16 ''(C) ETHICAL DISCLOSURE.—The Presi-
17 dent shall establish a system for public disclo-
18 sure by appointed members of the Board of fi-
19 nancial and other potential conflicts of interest
20 relating to such members. Appointed members
21 of the Board shall be treated as officers in the
22 executive branch for purposes of applying title
23 I of the Ethics in Government Act of 1978
24 (Public Law 95–521).

"(D) CONFLICTS OF INTEREST.—No individual may serve as an appointed member if that individual engages in any other business, vocation, or employment.

"(E) CONSULTATION WITH CONGRESS.—In selecting individuals for nominations for appointments to the Board, the President shall consult with—

"(i) the majority leader of the Senate concerning the appointment of 3 members;

"(ii) the Speaker of the House of Representatives concerning the appointment of 3 members;

"(iii) the minority leader of the Senate concerning the appointment of 3 members; and

"(iv) the minority leader of the House of Representatives concerning the appointment of 3 members.

"(2) TERM OF OFFICE.—Each appointed member shall hold office for a term of 6 years except that—

"(A) a member may not serve more than 2 full consecutive terms (but may be re-

appointed to 2 full consecutive terms after being appointed to fill a vacancy on the Board);

"(B) a member appointed to fill a vacancy occurring prior to the expiration of the term for which that member's predecessor was appointed shall be appointed for the remainder of such term;

"(C) a member may continue to serve after the expiration of the member's term until a successor has taken office; and

"(D) of the members first appointed under this section, 5 shall be appointed for a term of 1 year, 5 shall be appointed for a term of 3 years, and 5 shall be appointed for a term of 6 years, the term of each to be designated by the President at the time of nomination.

"(3) CHAIRPERSON.—

"(A) IN GENERAL.—The Chairperson shall be appointed by the President, by and with the advice and consent of the Senate, from among the members of the Board.

"(B) DUTIES.—The Chairperson shall be the principal executive officer of the Board, and shall exercise all of the executive and adminis-

trative functions of the Board, including functions of the Board with respect to—

"(i) the appointment and supervision of personnel employed by the Board;

"(ii) the distribution of business among personnel appointed and supervised by the Chairperson and among administrative units of the Board; and

"(iii) the use and expenditure of funds.

"(C) GOVERNANCE.—In carrying out any of the functions under subparagraph (B), the Chairperson shall be governed by the general policies established by the Board and by the decisions, findings, and determinations the Board shall by law be authorized to make.

"(D) REQUESTS FOR APPROPRIATIONS.—Requests or estimates for regular, supplemental, or deficiency appropriations on behalf of the Board may not be submitted by the Chairperson without the prior approval of a majority vote of the Board.

"(4) REMOVAL.—Any appointed member may be removed by the President for neglect of duty or malfeasance in office, but for no other cause.

1 "(h) VACANCIES; QUORUM; SEAL; VICE CHAIR-
2 PERSON; VOTING ON REPORTS.—
3 "(1) VACANCIES.—No vacancy on the Board
4 shall impair the right of the remaining members to
5 exercise all the powers of the Board.
6 "(2) QUORUM.—A majority of the appointed
7 members of the Board shall constitute a quorum for
8 the transaction of business, but a lesser number of
9 members may hold hearings.
10 "(3) SEAL.—The Board shall have an official
11 seal, of which judicial notice shall be taken.
12 "(4) VICE CHAIRPERSON.—The Board shall an-
13 nually elect a Vice Chairperson to act in the absence
14 or disability of the Chairperson or in case of a va-
15 cancy in the office of the Chairperson.
16 "(5) VOTING ON PROPOSALS.—Any proposal of
17 the Board must be approved by the majority of ap-
18 pointed members present.
19 "(i) POWERS OF THE BOARD.—
20 "(1) HEARINGS.—The Board may hold such
21 hearings, sit and act at such times and places, take
22 such testimony, and receive such evidence as the
23 Board considers advisable to carry out this section.
24 "(2) AUTHORITY TO INFORM RESEARCH PRIOR-
25 ITIES FOR DATA COLLECTION.—The Board may ad-

1 vise the Secretary on priorities for health services re-
2 search, particularly as such priorities pertain to nec-
3 essary changes and issues regarding payment re-
4 forms under Medicare.

5 ''(3) OBTAINING OFFICIAL DATA.—The Board
6 may secure directly from any department or agency
7 of the United States information necessary to enable
8 it to carry out this section. Upon request of the
9 Chairperson, the head of that department or agency
10 shall furnish that information to the Board on an
11 agreed upon schedule.

12 ''(4) POSTAL SERVICES.—The Board may use
13 the United States mails in the same manner and
14 under the same conditions as other departments and
15 agencies of the Federal Government.

16 ''(5) GIFTS.—The Board may accept, use, and
17 dispose of gifts or donations of services or property.

18 ''(6) OFFICES.—The Board shall maintain a
19 principal office and such field offices as it deter-
20 mines necessary, and may meet and exercise any of
21 its powers at any other place.

22 ''(j) PERSONNEL MATTERS.—

23 ''(1) COMPENSATION OF MEMBERS AND CHAIR-
24 PERSON.—Each appointed member, other than the
25 Chairperson, shall be compensated at a rate equal to

the annual rate of basic pay prescribed for level III of the Executive Schedule under section 5315 of title 5, United States Code. The Chairperson shall be compensated at a rate equal to the daily equivalent of the annual rate of basic pay prescribed for level II of the Executive Schedule under section 5315 of title 5, United States Code.

"(2) TRAVEL EXPENSES.—The appointed members shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Board.

"(3) STAFF.—

"(A) IN GENERAL.—The Chairperson may, without regard to the civil service laws and regulations, appoint and terminate an executive director and such other additional personnel as may be necessary to enable the Board to perform its duties. The employment of an executive director shall be subject to confirmation by the Board.

"(B) COMPENSATION.—The Chairperson may fix the compensation of the executive direc-

tor and other personnel without regard to chapter 51 and subchapter III of chapter 53 of title 5, United States Code, relating to classification of positions and General Schedule pay rates, except that the rate of pay for the executive director and other personnel may not exceed the rate payable for level V of the Executive Schedule under section 5316 of such title.

"(4) DETAIL OF GOVERNMENT EMPLOYEES.—Any Federal Government employee may be detailed to the Board without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

"(5) PROCUREMENT OF TEMPORARY AND INTERMITTENT SERVICES.—The Chairperson may procure temporary and intermittent services under section 3109(b) of title 5, United States Code, at rates for individuals which do not exceed the daily equivalent of the annual rate of basic pay prescribed for level V of the Executive Schedule under section 5316 of such title.

"(k) CONSUMER ADVISORY COUNCIL.—

"(1) IN GENERAL.—There is established a consumer advisory council to advise the Board on the

impact of payment policies under this title on consumers.

"(2) MEMBERSHIP.—

"(A) NUMBER AND APPOINTMENT.—The consumer advisory council shall be composed of 10 consumer representatives appointed by the Comptroller General of the United States, 1 from among each of the 10 regions established by the Secretary as of the date of enactment of this section.

"(B) QUALIFICATIONS.—The membership of the council shall represent the interests of consumers and particular communities.

"(3) DUTIES.—The consumer advisory council shall, subject to the call of the Board, meet not less frequently than 2 times each year in the District of Columbia.

"(4) OPEN MEETINGS.—Meetings of the consumer advisory council shall be open to the public.

"(5) ELECTION OF OFFICERS.—Members of the consumer advisory council shall elect their own officers.

"(6) APPLICATION OF FACA.—The Federal Advisory Committee Act (5 U.S.C. App.) shall apply to

1 the consumer advisory council except that section 14
2 of such Act shall not apply.
3 ''(l) DEFINITIONS.—In this section:
4 ''(1) BOARD; CHAIRPERSON; MEMBER.—The
5 terms 'Board', 'Chairperson', and 'Member' mean
6 the Independent Medicare Advisory Board estab-
7 lished under subsection (a) and the Chairperson and
8 any Member thereof, respectively.
9 ''(2) MEDICARE.—The term 'Medicare' means
10 the program established under this title, including
11 parts A, B, C, and D.
12 ''(3) MEDICARE BENEFICIARY.—The term
13 'Medicare beneficiary' means an individual who is
14 entitled to, or enrolled for, benefits under part A or
15 enrolled for benefits under part B.
16 ''(4) MEDICARE PROGRAM SPENDING.—The
17 term 'Medicare program spending' means program
18 spending under parts A, B, and D net of premiums.
19 ''(m) FUNDING.—
20 ''(1) IN GENERAL.—There are appropriated to
21 the Board to carry out its duties and functions—
22 ''(A) for fiscal year 2012, $15,000,000;
23 and
24 ''(B) for each subsequent fiscal year, the
25 amount appropriated under this paragraph for

the previous fiscal year increased by the annual percentage increase in the Consumer Price Index for All Urban Consumers (all items; United States city average) as of June of the previous fiscal year.

"(2) FROM TRUST FUNDS.—Sixty percent of amounts appropriated under paragraph (1) shall be derived by transfer from the Federal Hospital Insurance Trust Fund under section 1817 and 40 percent of amounts appropriated under such paragraph shall be derived by transfer from the Federal Supplementary Medical Insurance Trust Fund under section 1841.".

(2) LOBBYING COOLING-OFF PERIOD FOR MEMBERS OF THE INDEPENDENT MEDICARE ADVISORY BOARD.—Section 207(c) of title 18, United States Code, is amended by inserting at the end the following:

"(3) MEMBERS OF THE INDEPENDENT MEDICARE ADVISORY BOARD.—

"(A) IN GENERAL.—Paragraph (1) shall apply to a member of the Independent Medicare Advisory Board under section 1899A.

"(B) AGENCIES AND CONGRESS.—For purposes of paragraph (1), the agency in which the

individual described in subparagraph (A) served shall be considered to be the Independent Medicare Advisory Board, the Department of Health and Human Services, and the relevant committees of jurisdiction of Congress, including the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate.''.

(b) GAO STUDY AND REPORT ON DETERMINATION AND IMPLEMENTATION OF PAYMENT AND COVERAGE POLICIES UNDER THE MEDICARE PROGRAM.—

(1) INITIAL STUDY AND REPORT.—

(A) STUDY.—The Comptroller General of the United States (in this section referred to as the ''Comptroller General'') shall conduct a study on changes to payment policies, methodologies, and rates and coverage policies and methodologies under the Medicare program under title XVIII of the Social Security Act as a result of the recommendations contained in the proposals made by the Independent Medicare Advisory Board under section 1899A of such Act (as added by subsection (a)), including

1 an analysis of the effect of such recommenda-
2 tions on—
3 (i) Medicare beneficiary access to pro-
4 viders and items and services;
5 (ii) the affordability of Medicare pre-
6 miums and cost-sharing (including
7 deductibles, coinsurance, and copayments);
8 (iii) the potential impact of changes
9 on other government or private-sector pur-
10 chasers and payers of care; and
11 (iv) quality of patient care, including
12 patient experience, outcomes, and other
13 measures of care.
14 (B) REPORT.—Not later than July 1,
15 2015, the Comptroller General shall submit to
16 Congress a report containing the results of the
17 study conducted under subparagraph (A), to-
18 gether with recommendations for such legisla-
19 tion and administrative action as the Comp-
20 troller General determines appropriate.
21 (2) SUBSEQUENT STUDIES AND REPORTS.—The
22 Comptroller General shall periodically conduct such
23 additional studies and submit reports to Congress on
24 changes to Medicare payments policies, methodolo-
25 gies, and rates and coverage policies and methodolo-

gies as the Comptroller General determines appropriate, in consultation with the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate.

(c) CONFORMING AMENDMENTS.—Section 1805(b) of the Social Security Act (42 U.S.C. 1395b–6(b)) is amended—

(1) by redesignating paragraphs (4) through (8) as paragraphs (5) through (9), respectively; and

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

"(4) REVIEW AND COMMENT ON THE INDEPENDENT MEDICARE ADVISORY BOARD OR SECRETARIAL PROPOSAL.—If the Independent Medicare Advisory Board (as established under subsection (a) of section 1899A) or the Secretary submits a proposal to the Commission under such section in a year, the Commission shall review the proposal and, not later than March 1 of that year, submit to the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate written comments on such proposal. Such

comments may include such recommendations as the Commission deems appropriate.''.

Subtitle F—Health Care Quality Improvements

SEC. 3501. HEALTH CARE DELIVERY SYSTEM RESEARCH; QUALITY IMPROVEMENT TECHNICAL ASSISTANCE.

Part D of title IX of the Public Health Service Act, as amended by section 3013, is further amended by adding at the end the following:

"Subpart II—Health Care Quality Improvement Programs

"SEC. 933. HEALTH CARE DELIVERY SYSTEM RESEARCH.

''(a) PURPOSE.—The purposes of this section are to—

''(1) enable the Director to identify, develop, evaluate, disseminate, and provide training in innovative methodologies and strategies for quality improvement practices in the delivery of health care services that represent best practices (referred to as 'best practices') in health care quality, safety, and value; and

''(2) ensure that the Director is accountable for implementing a model to pursue such research in a

1 collaborative manner with other related Federal
2 agencies.
3 "(b) GENERAL FUNCTIONS OF THE CENTER.—The
4 Center for Quality Improvement and Patient Safety of the
5 Agency for Healthcare Research and Quality (referred to
6 in this section as the 'Center'), or any other relevant agen-
7 cy or department designated by the Director, shall—
8 "(1) carry out its functions using research from
9 a variety of disciplines, which may include epidemi-
10 ology, health services, sociology, psychology, human
11 factors engineering, biostatistics, health economics,
12 clinical research, and health informatics;
13 "(2) conduct or support activities consistent
14 with the purposes described in subsection (a), and
15 for—
16 "(A) best practices for quality improve-
17 ment practices in the delivery of health care
18 services; and
19 "(B) that include changes in processes of
20 care and the redesign of systems used by pro-
21 viders that will reliably result in intended health
22 outcomes, improve patient safety, and reduce
23 medical errors (such as skill development for
24 health care providers in team-based health care

1 delivery and rapid cycle process improvement)
2 and facilitate adoption of improved workflow;
3 ''(3) identify health care providers, including
4 health care systems, single institutions, and indi-
5 vidual providers, that—
6 ''(A) deliver consistently high-quality, effi-
7 cient health care services (as determined by the
8 Secretary); and
9 ''(B) employ best practices that are adapt-
10 able and scalable to diverse health care settings
11 or effective in improving care across diverse set-
12 tings;
13 ''(4) assess research, evidence, and knowledge
14 about what strategies and methodologies are most
15 effective in improving health care delivery;
16 ''(5) find ways to translate such information
17 rapidly and effectively into practice, and document
18 the sustainability of those improvements;
19 ''(6) create strategies for quality improvement
20 through the development of tools, methodologies,
21 and interventions that can successfully reduce vari-
22 ations in the delivery of health care;
23 ''(7) identify, measure, and improve organiza-
24 tional, human, or other causative factors, including
25 those related to the culture and system design of a

1 health care organization, that contribute to the suc-
2 cess and sustainability of specific quality improve-
3 ment and patient safety strategies;
4 ''(8) provide for the development of best prac-
5 tices in the delivery of health care services that—
6 ''(A) have a high likelihood of success,
7 based on structured review of empirical evi-
8 dence;
9 ''(B) are specified with sufficient detail of
10 the individual processes, steps, training, skills,
11 and knowledge required for implementation and
12 incorporation into workflow of health care prac-
13 titioners in a variety of settings;
14 ''(C) are designed to be readily adapted by
15 health care providers in a variety of settings;
16 and
17 ''(D) where applicable, assist health care
18 providers in working with other health care pro-
19 viders across the continuum of care and in en-
20 gaging patients and their families in improving
21 the care and patient health outcomes;
22 ''(9) provide for the funding of the activities of
23 organizations with recognized expertise and excel-
24 lence in improving the delivery of health care serv-
25 ices, including children's health care, by involving

multiple disciplines, managers of health care entities, broad development and training, patients, caregivers and families, and frontline health care workers, including activities for the examination of strategies to share best quality improvement practices and to promote excellence in the delivery of health care services; and

"(10) build capacity at the State and community level to lead quality and safety efforts through education, training, and mentoring programs to carry out the activities under paragraphs (1) through (9).

"(c) RESEARCH FUNCTIONS OF CENTER.—

"(1) IN GENERAL.—The Center shall support, such as through a contract or other mechanism, research on health care delivery system improvement and the development of tools to facilitate adoption of best practices that improve the quality, safety, and efficiency of health care delivery services. Such support may include establishing a Quality Improvement Network Research Program for the purpose of testing, scaling, and disseminating of interventions to improve quality and efficiency in health care. Recipients of funding under the Program may include

national, State, multi-State, or multi-site quality improvement networks.

"(2) RESEARCH REQUIREMENTS.—The research conducted pursuant to paragraph (1) shall—

"(A) address the priorities identified by the Secretary in the national strategic plan established under section 399HH;

"(B) identify areas in which evidence is insufficient to identify strategies and methodologies, taking into consideration areas of insufficient evidence identified by the entity with a contract under section 1890(a) of the Social Security Act in the report required under section 399JJ;

"(C) address concerns identified by health care institutions and providers and communicated through the Center pursuant to subsection (d);

"(D) reduce preventable morbidity, mortality, and associated costs of morbidity and mortality by building capacity for patient safety research;

"(E) support the discovery of processes for the reliable, safe, efficient, and responsive delivery of health care, taking into account discov-

1 eries from clinical research and comparative ef-
2 fectiveness research;
3 ''(F) allow communication of research find-
4 ings and translate evidence into practice rec-
5 ommendations that are adaptable to a variety
6 of settings, and which, as soon as practicable
7 after the establishment of the Center, shall in-
8 clude—
9 ''(i) the implementation of a national
10 application of Intensive Care Unit improve-
11 ment projects relating to the adult (includ-
12 ing geriatric), pediatric, and neonatal pa-
13 tient populations;
14 ''(ii) practical methods for addressing
15 health care associated infections, including
16 Methicillin-Resistant Staphylococcus
17 Aureus and Vancomycin-Resistant
18 Entercoccus infections and other emerging
19 infections; and
20 ''(iii) practical methods for reducing
21 preventable hospital admissions and re-
22 admissions;
23 ''(G) expand demonstration projects for
24 improving the quality of children's health care
25 and the use of health information technology,

such as through Pediatric Quality Improvement Collaboratives and Learning Networks, consistent with provisions of section 1139A of the Social Security Act for assessing and improving quality, where applicable;

"(H) identify and mitigate hazards by—

"(i) analyzing events reported to patient safety reporting systems and patient safety organizations; and

"(ii) using the results of such analyses to develop scientific methods of response to such events;

"(I) include the conduct of systematic reviews of existing practices that improve the quality, safety, and efficiency of health care delivery, as well as new research on improving such practices; and

"(J) include the examination of how to measure and evaluate the progress of quality and patient safety activities.

"(d) DISSEMINATION OF RESEARCH FINDINGS.—

"(1) PUBLIC AVAILABILITY.—The Director shall make the research findings of the Center available to the public through multiple media and appropriate formats to reflect the varying needs of health

1 care providers and consumers and diverse levels of
2 health literacy.
3 "(2) LINKAGE TO HEALTH INFORMATION TECH-
4 NOLOGY.—The Secretary shall ensure that research
5 findings and results generated by the Center are
6 shared with the Office of the National Coordinator
7 of Health Information Technology and used to in-
8 form the activities of the health information tech-
9 nology extension program under section 3012, as
10 well as any relevant standards, certification criteria,
11 or implementation specifications.
12 "(e) PRIORITIZATION.—The Director shall identify
13 and regularly update a list of processes or systems on
14 which to focus research and dissemination activities of the
15 Center, taking into account—
16 "(1) the cost to Federal health programs;
17 "(2) consumer assessment of health care experi-
18 ence;
19 "(3) provider assessment of such processes or
20 systems and opportunities to minimize distress and
21 injury to the health care workforce;
22 "(4) the potential impact of such processes or
23 systems on health status and function of patients,
24 including vulnerable populations including children;

1 "(5) the areas of insufficient evidence identified
2 under subsection (c)(2)(B); and
3 "(6) the evolution of meaningful use of health
4 information technology, as defined in section 3000.
5 "(f) COORDINATION.—The Center shall coordinate
6 its activities with activities conducted by the Center for
7 Medicare and Medicaid Innovation established under sec-
8 tion 1115A of the Social Security Act.
9 "(g) FUNDING.—There is authorized to be appro-
10 priated to carry out this section $20,000,000 for fiscal
11 years 2010 through 2014.

12 **"SEC. 934. QUALITY IMPROVEMENT TECHNICAL ASSIST-**
13 **ANCE AND IMPLEMENTATION.**

14 "(a) IN GENERAL.—The Director, through the Cen-
15 ter for Quality Improvement and Patient Safety of the
16 Agency for Healthcare Research and Quality (referred to
17 in this section as the 'Center'), shall award—
18 "(1) technical assistance grants or contracts to
19 eligible entities to provide technical support to insti-
20 tutions that deliver health care and health care pro-
21 viders (including rural and urban providers of serv-
22 ices and suppliers with limited infrastructure and fi-
23 nancial resources to implement and support quality
24 improvement activities, providers of services and
25 suppliers with poor performance scores, and pro-

viders of services and suppliers for which there are disparities in care among subgroups of patients) so that such institutions and providers understand, adapt, and implement the models and practices identified in the research conducted by the Center, including the Quality Improvement Networks Research Program; and

"(2) implementation grants or contracts to eligible entities to implement the models and practices described under paragraph (1).

"(b) ELIGIBLE ENTITIES.—

"(1) TECHNICAL ASSISTANCE AWARD.—To be eligible to receive a technical assistance grant or contract under subsection (a)(1), an entity—

"(A) may be a health care provider, health care provider association, professional society, health care worker organization, Indian health organization, quality improvement organization, patient safety organization, local quality improvement collaborative, the Joint Commission, academic health center, university, physician-based research network, primary care extension program established under section 399W, a Federal Indian Health Service program or a health program operated by an Indian tribe (as

1 defined in section 4 of the Indian Health Care
2 Improvement Act), or any other entity identi-
3 fied by the Secretary; and
4 "(B) shall have demonstrated expertise in
5 providing information and technical support
6 and assistance to health care providers regard-
7 ing quality improvement.
8 "(2) IMPLEMENTATION AWARD.—To be eligible
9 to receive an implementation grant or contract
10 under subsection (a)(2), an entity—
11 "(A) may be a hospital or other health
12 care provider or consortium or providers, as de-
13 termined by the Secretary; and
14 "(B) shall have demonstrated expertise in
15 providing information and technical support
16 and assistance to health care providers regard-
17 ing quality improvement.
18 "(c) APPLICATION.—
19 "(1) TECHNICAL ASSISTANCE AWARD.—To re-
20 ceive a technical assistance grant or contract under
21 subsection (a)(1), an eligible entity shall submit an
22 application to the Secretary at such time, in such
23 manner, and containing—
24 "(A) a plan for a sustainable business
25 model that may include a system of—

1 "(i) charging fees to institutions and
2 providers that receive technical support
3 from the entity; and
4 "(ii) reducing or eliminating such fees
5 for such institutions and providers that
6 serve low-income populations; and
7 "(B) such other information as the Direc-
8 tor may require.
9 "(2) IMPLEMENTATION AWARD.—To receive a
10 grant or contract under subsection (a)(2), an eligible
11 entity shall submit an application to the Secretary at
12 such time, in such manner, and containing—
13 "(A) a plan for implementation of a model
14 or practice identified in the research conducted
15 by the Center including—
16 "(i) financial cost, staffing require-
17 ments, and timeline for implementation;
18 and
19 "(ii) pre- and projected post-imple-
20 mentation quality measure performance
21 data in targeted improvement areas identi-
22 fied by the Secretary; and
23 "(B) such other information as the Direc-
24 tor may require.

1 "(d) MATCHING FUNDS.—The Director may not
2 award a grant or contract under this section to an entity
3 unless the entity agrees that it will make available (di-
4 rectly or through contributions from other public or pri-
5 vate entities) non-Federal contributions toward the activi-
6 ties to be carried out under the grant or contract in an
7 amount equal to $1 for each $5 of Federal funds provided
8 under the grant or contract. Such non-Federal matching
9 funds may be provided directly or through donations from
10 public or private entities and may be in cash or in-kind,
11 fairly evaluated, including plant, equipment, or services.
12 "(e) EVALUATION.—
13 "(1) IN GENERAL.—The Director shall evaluate
14 the performance of each entity that receives a grant
15 or contract under this section. The evaluation of an
16 entity shall include a study of—
17 "(A) the success of such entity in achiev-
18 ing the implementation, by the health care in-
19 stitutions and providers assisted by such entity,
20 of the models and practices identified in the re-
21 search conducted by the Center under section
22 933;
23 "(B) the perception of the health care in-
24 stitutions and providers assisted by such entity
25 regarding the value of the entity; and

"(C) where practicable, better patient health outcomes and lower cost resulting from the assistance provided by such entity.

"(2) EFFECT OF EVALUATION.—Based on the outcome of the evaluation of the entity under paragraph (1), the Director shall determine whether to renew a grant or contract with such entity under this section.

"(f) COORDINATION.—The entities that receive a grant or contract under this section shall coordinate with health information technology regional extension centers under section 3012(c) and the primary care extension program established under section 399W regarding the dissemination of quality improvement, system delivery reform, and best practices information.".

SEC. 3502. ESTABLISHING COMMUNITY HEALTH TEAMS TO SUPPORT THE PATIENT-CENTERED MEDICAL HOME.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the "Secretary") shall establish a program to provide grants to or enter into contracts with eligible entities to establish community-based interdisciplinary, interprofessional teams (referred to in this section as "health teams") to support primary care practices, including obstetrics and gyne-

1 cology practices, within the hospital service areas served
2 by the eligible entities. Grants or contracts shall be used
3 to—
4 (1) establish health teams to provide support
5 services to primary care providers; and
6 (2) provide capitated payments to primary care
7 providers as determined by the Secretary.
8 (b) ELIGIBLE ENTITIES.—To be eligible to receive a
9 grant or contract under subsection (a), an entity shall—
10 (1)(A) be a State or State-designated entity; or
11 (B) be an Indian tribe or tribal organization, as
12 defined in section 4 of the Indian Health Care Im-
13 provement Act;
14 (2) submit a plan for achieving long-term finan-
15 cial sustainability within 3 years;
16 (3) submit a plan for incorporating prevention
17 initiatives and patient education and care manage-
18 ment resources into the delivery of health care that
19 is integrated with community-based prevention and
20 treatment resources, where available;
21 (4) ensure that the health team established by
22 the entity includes an interdisciplinary, interprofes-
23 sional team of health care providers, as determined
24 by the Secretary; such team may include medical
25 specialists, nurses, pharmacists, nutritionists, dieti-

1 cians, social workers, behavioral and mental health
2 providers (including substance use disorder preven-
3 tion and treatment providers), doctors of chiro-
4 practic, licensed complementary and alternative med-
5 icine practitioners, and physicians' assistants;
6 (5) agree to provide services to eligible individ-
7 uals with chronic conditions, as described in section
8 1945 of the Social Security Act (as added by section
9 2703), in accordance with the payment methodology
10 established under subsection (c) of such section; and
11 (6) submit to the Secretary an application at
12 such time, in such manner, and containing such in-
13 formation as the Secretary may require.
14 (c) REQUIREMENTS FOR HEALTH TEAMS.—A health
15 team established pursuant to a grant or contract under
16 subsection (a) shall—
17 (1) establish contractual agreements with pri-
18 mary care providers to provide support services;
19 (2) support patient-centered medical homes, de-
20 fined as a mode of care that includes—
21 (A) personal physicians;
22 (B) whole person orientation;
23 (C) coordinated and integrated care;
24 (D) safe and high-quality care through evi-
25 dence-informed medicine, appropriate use of

1 health information technology, and continuous
2 quality improvements;
3 (E) expanded access to care; and
4 (F) payment that recognizes added value
5 from additional components of patient-centered
6 care;
7 (3) collaborate with local primary care providers
8 and existing State and community based resources
9 to coordinate disease prevention, chronic disease
10 management, transitioning between health care pro-
11 viders and settings and case management for pa-
12 tients, including children, with priority given to
13 those amenable to prevention and with chronic dis-
14 eases or conditions identified by the Secretary;
15 (4) in collaboration with local health care pro-
16 viders, develop and implement interdisciplinary,
17 interprofessional care plans that integrate clinical
18 and community preventive and health promotion
19 services for patients, including children, with a pri-
20 ority given to those amenable to prevention and with
21 chronic diseases or conditions identified by the Sec-
22 retary;
23 (5) incorporate health care providers, patients,
24 caregivers, and authorized representatives in pro-
25 gram design and oversight;

1 (6) provide support necessary for local primary
2 care providers to—
3 (A) coordinate and provide access to high-
4 quality health care services;
5 (B) coordinate and provide access to pre-
6 ventive and health promotion services;
7 (C) provide access to appropriate specialty
8 care and inpatient services;
9 (D) provide quality-driven, cost-effective,
10 culturally appropriate, and patient- and family-
11 centered health care;
12 (E) provide access to pharmacist-delivered
13 medication management services, including
14 medication reconciliation;
15 (F) provide coordination of the appropriate
16 use of complementary and alternative (CAM)
17 services to those who request such services;
18 (G) promote effective strategies for treat-
19 ment planning, monitoring health outcomes and
20 resource use, sharing information, treatment
21 decision support, and organizing care to avoid
22 duplication of service and other medical man-
23 agement approaches intended to improve qual-
24 ity and value of health care services;

(H) provide local access to the continuum of health care services in the most appropriate setting, including access to individuals that implement the care plans of patients and coordinate care, such as integrative health care practitioners;

(I) collect and report data that permits evaluation of the success of the collaborative effort on patient outcomes, including collection of data on patient experience of care, and identification of areas for improvement; and

(J) establish a coordinated system of early identification and referral for children at risk for developmental or behavioral problems such as through the use of infolines, health information technology, or other means as determined by the Secretary;

(7) provide 24-hour care management and support during transitions in care settings including—

(A) a transitional care program that provides onsite visits from the care coordinator, assists with the development of discharge plans and medication reconciliation upon admission to and discharge from the hospitals, nursing home, or other institution setting;

(B) discharge planning and counseling support to providers, patients, caregivers, and authorized representatives;

(C) assuring that post-discharge care plans include medication management, as appropriate;

(D) referrals for mental and behavioral health services, which may include the use of infolines; and

(E) transitional health care needs from adolescence to adulthood;

(8) serve as a liaison to community prevention and treatment programs;

(9) demonstrate a capacity to implement and maintain health information technology that meets the requirements of certified EHR technology (as defined in section 3000 of the Public Health Service Act (42 U.S.C. 300jj)) to facilitate coordination among members of the applicable care team and affiliated primary care practices; and

(10) where applicable, report to the Secretary information on quality measures used under section 399JJ of the Public Health Service Act.

(d) REQUIREMENT FOR PRIMARY CARE PROVIDERS.—A provider who contracts with a care team shall—

(1) provide a care plan to the care team for each patient participant;

(2) provide access to participant health records; and

(3) meet regularly with the care team to ensure integration of care.

(e) REPORTING TO SECRETARY.—An entity that receives a grant or contract under subsection (a) shall submit to the Secretary a report that describes and evaluates, as requested by the Secretary, the activities carried out by the entity under subsection (c).

(f) DEFINITION OF PRIMARY CARE.—In this section, the term ''primary care'' means the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.

SEC. 3503. MEDICATION MANAGEMENT SERVICES IN TREATMENT OF CHRONIC DISEASE.

Title IX of the Public Health Service Act (42 U.S.C. 299 et seq.), as amended by section 3501, is further amended by inserting after section 934 the following:

"SEC. 935. GRANTS OR CONTRACTS TO IMPLEMENT MEDICATION MANAGEMENT SERVICES IN TREATMENT OF CHRONIC DISEASES.

"(a) IN GENERAL.—The Secretary, acting through the Patient Safety Research Center established in section 933 (referred to in this section as the 'Center'), shall establish a program to provide grants or contracts to eligible entities to implement medication management (referred to in this section as 'MTM') services provided by licensed pharmacists, as a collaborative, multidisciplinary, interprofessional approach to the treatment of chronic diseases for targeted individuals, to improve the quality of care and reduce overall cost in the treatment of such diseases. The Secretary shall commence the program under this section not later than May 1, 2010.

"(b) ELIGIBLE ENTITIES.—To be eligible to receive a grant or contract under subsection (a), an entity shall—

"(1) provide a setting appropriate for MTM services, as recommended by the experts described in subsection (e);

1 "(2) submit to the Secretary a plan for achiev-
2 ing long-term financial sustainability;
3 "(3) where applicable, submit a plan for coordi-
4 nating MTM services through local community
5 health teams established in section 3502 of the Pa-
6 tient Protection and Affordable Care Act or in col-
7 laboration with primary care extension programs es-
8 tablished in section 399W;
9 "(4) submit a plan for meeting the require-
10 ments under subsection (c); and
11 "(5) submit to the Secretary such other infor-
12 mation as the Secretary may require.
13 "(c) MTM SERVICES TO TARGETED INDIVIDUALS.—
14 The MTM services provided with the assistance of a grant
15 or contract awarded under subsection (a) shall, as allowed
16 by State law including applicable collaborative pharmacy
17 practice agreements, include—
18 "(1) performing or obtaining necessary assess-
19 ments of the health and functional status of each
20 patient receiving such MTM services;
21 "(2) formulating a medication treatment plan
22 according to therapeutic goals agreed upon by the
23 prescriber and the patient or caregiver or authorized
24 representative of the patient;

1 ''(3) selecting, initiating, modifying, recom-
2 mending changes to, or administering medication
3 therapy;
4 ''(4) monitoring, which may include access to,
5 ordering, or performing laboratory assessments, and
6 evaluating the response of the patient to therapy, in-
7 cluding safety and effectiveness;
8 ''(5) performing an initial comprehensive medi-
9 cation review to identify, resolve, and prevent medi-
10 cation-related problems, including adverse drug
11 events, quarterly targeted medication reviews for on-
12 going monitoring, and additional followup interven-
13 tions on a schedule developed collaboratively with
14 the prescriber;
15 ''(6) documenting the care delivered and com-
16 municating essential information about such care,
17 including a summary of the medication review, and
18 the recommendations of the pharmacist to other ap-
19 propriate health care providers of the patient in a
20 timely fashion;
21 ''(7) providing education and training designed
22 to enhance the understanding and appropriate use of
23 the medications by the patient, caregiver, and other
24 authorized representative;

1 "(8) providing information, support services,
2 and resources and strategies designed to enhance
3 patient adherence with therapeutic regimens;
4 "(9) coordinating and integrating MTM serv-
5 ices within the broader health care management
6 services provided to the patient; and
7 "(10) such other patient care services allowed
8 under pharmacist scopes of practice in use in other
9 Federal programs that have implemented MTM
10 services.
11 "(d) TARGETED INDIVIDUALS.—MTM services pro-
12 vided by licensed pharmacists under a grant or contract
13 awarded under subsection (a) shall be offered to targeted
14 individuals who—
15 "(1) take 4 or more prescribed medications (in-
16 cluding over-the-counter medications and dietary
17 supplements);
18 "(2) take any 'high risk' medications;
19 "(3) have 2 or more chronic diseases, as identi-
20 fied by the Secretary; or
21 "(4) have undergone a transition of care, or
22 other factors, as determined by the Secretary, that
23 are likely to create a high risk of medication-related
24 problems.

1 "(e) CONSULTATION WITH EXPERTS.—In designing
2 and implementing MTM services provided under grants or
3 contracts awarded under subsection (a), the Secretary
4 shall consult with Federal, State, private, public-private,
5 and academic entities, pharmacy and pharmacist organi-
6 zations, health care organizations, consumer advocates,
7 chronic disease groups, and other stakeholders involved
8 with the research, dissemination, and implementation of
9 pharmacist-delivered MTM services, as the Secretary de-
10 termines appropriate. The Secretary, in collaboration with
11 this group, shall determine whether it is possible to incor-
12 porate rapid cycle process improvement concepts in use
13 in other Federal programs that have implemented MTM
14 services.

15 "(f) REPORTING TO THE SECRETARY.—An entity
16 that receives a grant or contract under subsection (a) shall
17 submit to the Secretary a report that describes and evalu-
18 ates, as requested by the Secretary, the activities carried
19 out under subsection (c), including quality measures en-
20 dorsed by the entity with a contract under section 1890
21 of the Social Security Act, as determined by the Secretary.

22 "(g) EVALUATION AND REPORT.—The Secretary
23 shall submit to the relevant committees of Congress a re-
24 port which shall—

1 ''(1) assess the clinical effectiveness of phar-
2 macist-provided services under the MTM services
3 program, as compared to usual care, including an
4 evaluation of whether enrollees maintained better
5 health with fewer hospitalizations and emergency
6 room visits than similar patients not enrolled in the
7 program;
8 ''(2) assess changes in overall health care re-
9 source use by targeted individuals;
10 ''(3) assess patient and prescriber satisfaction
11 with MTM services;
12 ''(4) assess the impact of patient-cost sharing
13 requirements on medication adherence and rec-
14 ommendations for modifications;
15 ''(5) identify and evaluate other factors that
16 may impact clinical and economic outcomes, includ-
17 ing demographic characteristics, clinical characteris-
18 tics, and health services use of the patient, as well
19 as characteristics of the regimen, pharmacy benefit,
20 and MTM services provided; and
21 ''(6) evaluate the extent to which participating
22 pharmacists who maintain a dispensing role have a
23 conflict of interest in the provision of MTM services,
24 and if such conflict is found, provide recommenda-

tions on how such a conflict might be appropriately addressed.

"(h) GRANTS OR CONTRACTS TO FUND DEVELOPMENT OF PERFORMANCE MEASURES.—The Secretary may, through the quality measure development program under section 931 of the Public Health Service Act, award grants or contracts to eligible entities for the purpose of funding the development of performance measures that assess the use and effectiveness of medication therapy management services.".

SEC. 3504. DESIGN AND IMPLEMENTATION OF REGIONALIZED SYSTEMS FOR EMERGENCY CARE.

(a) IN GENERAL.—Title XII of the Public Health Service Act (42 U.S.C. 300d et seq.) is amended—

(1) in section 1203—

(A) in the section heading, by inserting "**FOR TRAUMA SYSTEMS**" after "**GRANTS**"; and

(B) in subsection (a), by striking "Administrator of the Health Resources and Services Administration" and inserting "Assistant Secretary for Preparedness and Response";

(2) by inserting after section 1203 the following:

"SEC. 1204. COMPETITIVE GRANTS FOR REGIONALIZED SYSTEMS FOR EMERGENCY CARE RESPONSE.

"(a) IN GENERAL.—The Secretary, acting through the Assistant Secretary for Preparedness and Response, shall award not fewer than 4 multiyear contracts or competitive grants to eligible entities to support pilot projects that design, implement, and evaluate innovative models of regionalized, comprehensive, and accountable emergency care and trauma systems.

"(b) ELIGIBLE ENTITY; REGION.—In this section:

"(1) ELIGIBLE ENTITY.—The term 'eligible entity' means—

"(A) a State or a partnership of 1 or more States and 1 or more local governments; or

"(B) an Indian tribe (as defined in section 4 of the Indian Health Care Improvement Act) or a partnership of 1 or more Indian tribes.

"(2) REGION.—The term 'region' means an area within a State, an area that lies within multiple States, or a similar area (such as a multicounty area), as determined by the Secretary.

"(3) EMERGENCY SERVICES.—The term 'emergency services' includes acute, prehospital, and trauma care.

"(c) PILOT PROJECTS.—The Secretary shall award a contract or grant under subsection (a) to an eligible enti-

1 ty that proposes a pilot project to design, implement, and
2 evaluate an emergency medical and trauma system that—
3 "(1) coordinates with public health and safety
4 services, emergency medical services, medical facili-
5 ties, trauma centers, and other entities in a region
6 to develop an approach to emergency medical and
7 trauma system access throughout the region, includ-
8 ing 9–1–1 Public Safety Answering Points and
9 emergency medical dispatch;
10 "(2) includes a mechanism, such as a regional
11 medical direction or transport communications sys-
12 tem, that operates throughout the region to ensure
13 that the patient is taken to the medically appro-
14 priate facility (whether an initial facility or a higher-
15 level facility) in a timely fashion;
16 "(3) allows for the tracking of prehospital and
17 hospital resources, including inpatient bed capacity,
18 emergency department capacity, trauma center ca-
19 pacity, on-call specialist coverage, ambulance diver-
20 sion status, and the coordination of such tracking
21 with regional communications and hospital destina-
22 tion decisions; and
23 "(4) includes a consistent region-wide
24 prehospital, hospital, and interfacility data manage-
25 ment system that—

1 "(A) submits data to the National EMS
2 Information System, the National Trauma Data
3 Bank, and others;
4 "(B) reports data to appropriate Federal
5 and State databanks and registries; and
6 "(C) contains information sufficient to
7 evaluate key elements of prehospital care, hos-
8 pital destination decisions, including initial hos-
9 pital and interfacility decisions, and relevant
10 health outcomes of hospital care.
11 "(d) APPLICATION.—
12 "(1) IN GENERAL.—An eligible entity that
13 seeks a contract or grant described in subsection (a)
14 shall submit to the Secretary an application at such
15 time and in such manner as the Secretary may re-
16 quire.
17 "(2) APPLICATION INFORMATION.—Each appli-
18 cation shall include—
19 "(A) an assurance from the eligible entity
20 that the proposed system—
21 "(i) has been coordinated with the ap-
22 plicable State Office of Emergency Medical
23 Services (or equivalent State office);
24 "(ii) includes consistent indirect and
25 direct medical oversight of prehospital,

1 hospital, and interfacility transport
2 throughout the region;
3 ''(iii) coordinates prehospital treat-
4 ment and triage, hospital destination, and
5 interfacility transport throughout the re-
6 gion;
7 ''(iv) includes a categorization or des-
8 ignation system for special medical facili-
9 ties throughout the region that is inte-
10 grated with transport and destination pro-
11 tocols;
12 ''(v) includes a regional medical direc-
13 tion, patient tracking, and resource alloca-
14 tion system that supports day-to-day emer-
15 gency care and surge capacity and is inte-
16 grated with other components of the na-
17 tional and State emergency preparedness
18 system; and
19 ''(vi) addresses pediatric concerns re-
20 lated to integration, planning, prepared-
21 ness, and coordination of emergency med-
22 ical services for infants, children and ado-
23 lescents; and
24 ''(B) such other information as the Sec-
25 retary may require.

1 "(e) REQUIREMENT OF MATCHING FUNDS.—

2 "(1) IN GENERAL.—The Secretary may not
3 make a grant under this section unless the State (or
4 consortia of States) involved agrees, with respect to
5 the costs to be incurred by the State (or consortia)
6 in carrying out the purpose for which such grant
7 was made, to make available non-Federal contribu-
8 tions (in cash or in kind under paragraph (2)) to-
9 ward such costs in an amount equal to not less than
10 $1 for each $3 of Federal funds provided in the
11 grant. Such contributions may be made directly or
12 through donations from public or private entities.

13 "(2) NON-FEDERAL CONTRIBUTIONS.—Non-
14 Federal contributions required in paragraph (1) may
15 be in cash or in kind, fairly evaluated, including
16 equipment or services (and excluding indirect or
17 overhead costs). Amounts provided by the Federal
18 Government, or services assisted or subsidized to
19 any significant extent by the Federal Government,
20 may not be included in determining the amount of
21 such non-Federal contributions.

22 "(f) PRIORITY.—The Secretary shall give priority for
23 the award of the contracts or grants described in sub-
24 section (a) to any eligible entity that serves a population

in a medically underserved area (as defined in section 330(b)(3)).

"(g) REPORT.—Not later than 90 days after the completion of a pilot project under subsection (a), the recipient of such contract or grant described in shall submit to the Secretary a report containing the results of an evaluation of the program, including an identification of—

"(1) the impact of the regional, accountable emergency care and trauma system on patient health outcomes for various critical care categories, such as trauma, stroke, cardiac emergencies, neurological emergencies, and pediatric emergencies;

"(2) the system characteristics that contribute to the effectiveness and efficiency of the program (or lack thereof);

"(3) methods of assuring the long-term financial sustainability of the emergency care and trauma system;

"(4) the State and local legislation necessary to implement and to maintain the system;

"(5) the barriers to developing regionalized, accountable emergency care and trauma systems, as well as the methods to overcome such barriers; and

"(6) recommendations on the utilization of available funding for future regionalization efforts.

"(h) DISSEMINATION OF FINDINGS.—The Secretary shall, as appropriate, disseminate to the public and to the appropriate Committees of the Congress, the information contained in a report made under subsection (g)."; and

(3) in section 1232—

(A) in subsection (a), by striking "appropriated" and all that follows through the period at the end and inserting "appropriated $24,000,000 for each of fiscal years 2010 through 2014."; and

(B) by inserting after subsection (c) the following:

"(d) AUTHORITY.—For the purpose of carrying out parts A through C, beginning on the date of enactment of the Patient Protection and Affordable Care Act, the Secretary shall transfer authority in administering grants and related authorities under such parts from the Administrator of the Health Resources and Services Administration to the Assistant Secretary for Preparedness and Response.".

(b) SUPPORT FOR EMERGENCY MEDICINE RESEARCH.—Part H of title IV of the Public Health Service Act (42 U.S.C. 289 et seq.) is amended by inserting after the section 498C the following:

"SEC. 498D. SUPPORT FOR EMERGENCY MEDICINE RESEARCH.

"(a) EMERGENCY MEDICAL RESEARCH.—The Secretary shall support Federal programs administered by the National Institutes of Health, the Agency for Healthcare Research and Quality, the Health Resources and Services Administration, the Centers for Disease Control and Prevention, and other agencies involved in improving the emergency care system to expand and accelerate research in emergency medical care systems and emergency medicine, including—

"(1) the basic science of emergency medicine;

"(2) the model of service delivery and the components of such models that contribute to enhanced patient health outcomes;

"(3) the translation of basic scientific research into improved practice; and

"(4) the development of timely and efficient delivery of health services.

"(b) PEDIATRIC EMERGENCY MEDICAL RESEARCH.—The Secretary shall support Federal programs administered by the National Institutes of Health, the Agency for Healthcare Research and Quality, the Health Resources and Services Administration, the Centers for Disease Control and Prevention, and other agencies to coordinate and expand research in pediatric emergency med-

1 ical care systems and pediatric emergency medicine, in-
2 cluding—
3 "(1) an examination of the gaps and opportuni-
4 ties in pediatric emergency care research and a
5 strategy for the optimal organization and funding of
6 such research;
7 "(2) the role of pediatric emergency services as
8 an integrated component of the overall health sys-
9 tem;
10 "(3) system-wide pediatric emergency care plan-
11 ning, preparedness, coordination, and funding;
12 "(4) pediatric training in professional edu-
13 cation; and
14 "(5) research in pediatric emergency care, spe-
15 cifically on the efficacy, safety, and health outcomes
16 of medications used for infants, children, and adoles-
17 cents in emergency care settings in order to improve
18 patient safety.
19 "(c) IMPACT RESEARCH.—The Secretary shall sup-
20 port research to determine the estimated economic impact
21 of, and savings that result from, the implementation of
22 coordinated emergency care systems.
23 "(d) AUTHORIZATION OF APPROPRIATIONS.—There
24 are authorized to be appropriated to carry out this section

such sums as may be necessary for each of fiscal years 2010 through 2014.''.

SEC. 3505. TRAUMA CARE CENTERS AND SERVICE AVAILABILITY.

(a) TRAUMA CARE CENTERS.—

(1) GRANTS FOR TRAUMA CARE CENTERS.—Section 1241 of the Public Health Service Act (42 U.S.C. 300d–41) is amended by striking subsections (a) and (b) and inserting the following:

''(a) IN GENERAL.—The Secretary shall establish 3 programs to award grants to qualified public, nonprofit Indian Health Service, Indian tribal, and urban Indian trauma centers—

''(1) to assist in defraying substantial uncompensated care costs;

''(2) to further the core missions of such trauma centers, including by addressing costs associated with patient stabilization and transfer, trauma education and outreach, coordination with local and regional trauma systems, essential personnel and other fixed costs, and expenses associated with employee and non-employee physician services; and

''(3) to provide emergency relief to ensure the continued and future availability of trauma services.

"(b) MINIMUM QUALIFICATIONS OF TRAUMA CENTERS.—

"(1) PARTICIPATION IN TRAUMA CARE SYSTEM OPERATING UNDER CERTAIN PROFESSIONAL GUIDELINES.—Except as provided in paragraph (2), the Secretary may not award a grant to a trauma center under subsection (a) unless the trauma center is a participant in a trauma system that substantially complies with section 1213.

"(2) EXEMPTION.—Paragraph (1) shall not apply to trauma centers that are located in States with no existing trauma care system.

"(3) QUALIFICATION FOR SUBSTANTIAL UNCOMPENSATED CARE COSTS.—The Secretary shall award substantial uncompensated care grants under subsection (a)(1) only to trauma centers meeting at least 1 of the criteria in 1 of the following 3 categories:

"(A) CATEGORY A.—The criteria for category A are as follows:

"(i) At least 40 percent of the visits in the emergency department of the hospital in which the trauma center is located were charity or self-pay patients.

"(ii) At least 50 percent of the visits in such emergency department were Medicaid (under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.)) and charity and self-pay patients combined.

"(B) CATEGORY B.—The criteria for category B are as follows:

"(i) At least 35 percent of the visits in the emergency department were charity or self-pay patients.

"(ii) At least 50 percent of the visits in the emergency department were Medicaid and charity and self-pay patients combined.

"(C) CATEGORY C.—The criteria for category C are as follows:

"(i) At least 20 percent of the visits in the emergency department were charity or self-pay patients.

"(ii) At least 30 percent of the visits in the emergency department were Medicaid and charity and self-pay patients combined.

"(4) TRAUMA CENTERS IN 1115 WAIVER STATES.—Notwithstanding paragraph (3), the Sec-

1 retary may award a substantial uncompensated care
2 grant to a trauma center under subsection (a)(1) if
3 the trauma center qualifies for funds under a Low
4 Income Pool or Safety Net Care Pool established
5 through a waiver approved under section 1115 of the
6 Social Security Act (42 U.S.C. 1315).

7 ''(5) DESIGNATION.—The Secretary may not
8 award a grant to a trauma center unless such trau-
9 ma center is verified by the American College of
10 Surgeons or designated by an equivalent State or
11 local agency.

12 ''(c) ADDITIONAL REQUIREMENTS.—The Secretary
13 may not award a grant to a trauma center under sub-
14 section (a)(1) unless such trauma center—

15 ''(1) submits to the Secretary a plan satisfac-
16 tory to the Secretary that demonstrates a continued
17 commitment to serving trauma patients regardless of
18 their ability to pay; and

19 ''(2) has policies in place to assist patients who
20 cannot pay for part or all of the care they receive,
21 including a sliding fee scale, and to ensure fair bill-
22 ing and collection practices.''.

23 (2) CONSIDERATIONS IN MAKING GRANTS.—
24 Section 1242 of the Public Health Service Act (42

U.S.C. 300d–42) is amended by striking subsections (a) and (b) and inserting the following:

"(a) SUBSTANTIAL UNCOMPENSATED CARE AWARDS.—

"(1) IN GENERAL.—The Secretary shall establish an award basis for each eligible trauma center for grants under section 1241(a)(1) according to the percentage described in paragraph (2), subject to the requirements of section 1241(b)(3).

"(2) PERCENTAGES.—The applicable percentages are as follows:

"(A) With respect to a category A trauma center, 100 percent of the uncompensated care costs.

"(B) With respect to a category B trauma center, not more than 75 percent of the uncompensated care costs.

"(C) With respect to a category C trauma center, not more than 50 percent of the uncompensated care costs.

"(b) CORE MISSION AWARDS.—

"(1) IN GENERAL.—In awarding grants under section 1241(a)(2), the Secretary shall—

1 "(A) reserve 25 percent of the amount al-
2 located for core mission awards for Level III
3 and Level IV trauma centers; and
4 "(B) reserve 25 percent of the amount al-
5 located for core mission awards for large urban
6 Level I and II trauma centers—
7 "(i) that have at least 1 graduate
8 medical education fellowship in trauma or
9 trauma related specialties for which de-
10 mand is exceeding supply;
11 "(ii) for which—
12 "(I) annual uncompensated care
13 costs exceed $10,000,000; or
14 "(II) at least 20 percent of emer-
15 gency department visits are charity or
16 self-pay or Medicaid patients; and
17 "(iii) that are not eligible for substan-
18 tial uncompensated care awards under sec-
19 tion 1241(a)(1).
20 "(c) EMERGENCY AWARDS.—In awarding grants
21 under section 1241(a)(3), the Secretary shall—
22 "(1) give preference to any application sub-
23 mitted by a trauma center that provides trauma care
24 in a geographic area in which the availability of
25 trauma care has significantly decreased or will sig-

1 nificantly decrease if the center is forced to close or
2 downgrade service or growth in demand for trauma
3 services exceeds capacity; and
4 ''(2) reallocate any emergency awards funds not
5 obligated due to insufficient, or a lack of qualified,
6 applications to the significant uncompensated care
7 award program.''.
8 (3) CERTAIN AGREEMENTS.—Section 1243 of
9 the Public Health Service Act (42 U.S.C. 300d–43)
10 is amended by striking subsections (a), (b), and (c)
11 and inserting the following:
12 ''(a) MAINTENANCE OF FINANCIAL SUPPORT.—The
13 Secretary may require a trauma center receiving a grant
14 under section 1241(a) to maintain access to trauma serv-
15 ices at comparable levels to the prior year during the grant
16 period.
17 ''(b) TRAUMA CARE REGISTRY.—The Secretary may
18 require the trauma center receiving a grant under section
19 1241(a) to provide data to a national and centralized reg-
20 istry of trauma cases, in accordance with guidelines devel-
21 oped by the American College of Surgeons, and as the Sec-
22 retary may otherwise require.''.
23 (4) GENERAL PROVISIONS.—Section 1244 of
24 the Public Health Service Act (42 U.S.C. 300d–44)

is amended by striking subsections (a), (b), and (c) and inserting the following:

"(a) APPLICATION.—The Secretary may not award a grant to a trauma center under section 1241(a) unless such center submits an application for the grant to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this part.

"(b) LIMITATION ON DURATION OF SUPPORT.—The period during which a trauma center receives payments under a grant under section 1241(a)(3) shall be for 3 fiscal years, except that the Secretary may waive such requirement for a center and authorize such center to receive such payments for 1 additional fiscal year.

"(c) LIMITATION ON AMOUNT OF GRANT.—Notwithstanding section 1242(a), a grant under section 1241 may not be made in an amount exceeding $2,000,000 for each fiscal year.

"(d) ELIGIBILITY.—Except as provided in section 1242(b)(1)(B)(iii), acquisition of, or eligibility for, a grant under section 1241(a) shall not preclude a trauma center from being eligible for other grants described in such section.

"(e) FUNDING DISTRIBUTION.—Of the total amount appropriated for a fiscal year under section 1245, 70 percent shall be used for substantial uncompensated care awards under section 1241(a)(1), 20 percent shall be used for core mission awards under section 1241(a)(2), and 10 percent shall be used for emergency awards under section 1241(a)(3).

"(f) MINIMUM ALLOWANCE.—Notwithstanding subsection (e), if the amount appropriated for a fiscal year under section 1245 is less than $25,000,000, all available funding for such fiscal year shall be used for substantial uncompensated care awards under section 1241(a)(1).

"(g) SUBSTANTIAL UNCOMPENSATED CARE AWARD DISTRIBUTION AND PROPORTIONAL SHARE.—Notwithstanding section 1242(a), of the amount appropriated for substantial uncompensated care grants for a fiscal year, the Secretary shall—

"(1) make available—

"(A) 50 percent of such funds for category A trauma center grantees;

"(B) 35 percent of such funds for category B trauma center grantees; and

"(C) 15 percent of such funds for category C trauma center grantees; and

"(2) provide available funds within each category in a manner proportional to the award basis specified in section 1242(a)(2) to each eligible trauma center.

"(h) REPORT.—Beginning 2 years after the date of enactment of the Patient Protection and Affordable Care Act, and every 2 years thereafter, the Secretary shall biennially report to Congress regarding the status of the grants made under section 1241 and on the overall financial stability of trauma centers.".

(5) AUTHORIZATION OF APPROPRIATIONS.—Section 1245 of the Public Health Service Act (42 U.S.C. 300d–45) is amended to read as follows:

"SEC. 1245. AUTHORIZATION OF APPROPRIATIONS.

"For the purpose of carrying out this part, there are authorized to be appropriated $100,000,000 for fiscal year 2009, and such sums as may be necessary for each of fiscal years 2010 through 2015. Such authorization of appropriations is in addition to any other authorization of appropriations or amounts that are available for such purpose.".

(6) DEFINITION.—Part D of title XII of the Public Health Service Act (42 U.S.C. 300d–41 et seq.) is amended by adding at the end the following:

"SEC. 1246. DEFINITION.

"In this part, the term 'uncompensated care costs' means unreimbursed costs from serving self-pay, charity, or Medicaid patients, without regard to payment under section 1923 of the Social Security Act, all of which are attributable to emergency care and trauma care, including costs related to subsequent inpatient admissions to the hospital.".

(b) TRAUMA SERVICE AVAILABILITY.—Title XII of the Public Health Service Act (42 U.S.C. 300d et seq.) is amended by adding at the end the following:

"PART H—TRAUMA SERVICE AVAILABILITY

"SEC. 1281. GRANTS TO STATES.

"(a) ESTABLISHMENT.—To promote universal access to trauma care services provided by trauma centers and trauma-related physician specialties, the Secretary shall provide funding to States to enable such States to award grants to eligible entities for the purposes described in this section.

"(b) AWARDING OF GRANTS BY STATES.—Each State may award grants to eligible entities within the State for the purposes described in subparagraph (d).

"(c) ELIGIBILITY.—

"(1) IN GENERAL.—To be eligible to receive a grant under subsection (b) an entity shall—

"(A) be—

"(i) a public or nonprofit trauma center or consortium thereof that meets that requirements of paragraphs (1), (2), and (5) of section 1241(b);

"(ii) a safety net public or nonprofit trauma center that meets the requirements of paragraphs (1) through (5) of section 1241(b); or

"(iii) a hospital in an underserved area (as defined by the State) that seeks to establish new trauma services; and

"(B) submit to the State an application at such time, in such manner, and containing such information as the State may require.

"(2) LIMITATION.—A State shall use at least 40 percent of the amount available to the State under this part for a fiscal year to award grants to safety net trauma centers described in paragraph (1)(A)(ii).

"(d) USE OF FUNDS.—The recipient of a grant under subsection (b) shall carry out 1 or more of the following activities consistent with subsection (b):

"(1) Providing trauma centers with funding to support physician compensation in trauma-related physician specialties where shortages exist in the re-

gion involved, with priority provided to safety net trauma centers described in subsection (c)(1)(A)(ii).

''(2) Providing for individual safety net trauma center fiscal stability and costs related to having service that is available 24 hours a day, 7 days a week, with priority provided to safety net trauma centers described in subsection (c)(1)(A)(ii) located in urban, border, and rural areas.

''(3) Reducing trauma center overcrowding at specific trauma centers related to throughput of trauma patients.

''(4) Establishing new trauma services in underserved areas as defined by the State.

''(5) Enhancing collaboration between trauma centers and other hospitals and emergency medical services personnel related to trauma service availability.

''(6) Making capital improvements to enhance access and expedite trauma care, including providing helipads and associated safety infrastructure.

''(7) Enhancing trauma surge capacity at specific trauma centers.

''(8) Ensuring expedient receipt of trauma patients transported by ground or air to the appropriate trauma center.

"(9) Enhancing interstate trauma center collaboration.

"(e) LIMITATION.—

"(1) IN GENERAL.—A State may use not more than 20 percent of the amount available to the State under this part for a fiscal year for administrative costs associated with awarding grants and related costs.

"(2) MAINTENANCE OF EFFORT.—The Secretary may not provide funding to a State under this part unless the State agrees that such funds will be used to supplement and not supplant State funding otherwise available for the activities and costs described in this part.

"(f) DISTRIBUTION OF FUNDS.—The following shall apply with respect to grants provided in this part:

"(1) LESS THAN $10,000,000.—If the amount of appropriations for this part in a fiscal year is less than $10,000,000, the Secretary shall divide such funding evenly among only those States that have 1 or more trauma centers eligible for funding under section 1241(b)(3)(A).

"(2) LESS THAN $20,000,000.—If the amount of appropriations in a fiscal year is less than $20,000,000, the Secretary shall divide such funding

evenly among only those States that have 1 or more trauma centers eligible for funding under subparagraphs (A) and (B) of section 1241(b)(3).

"(3) LESS THAN $30,000,000.—If the amount of appropriations for this part in a fiscal year is less than $30,000,000, the Secretary shall divide such funding evenly among only those States that have 1 or more trauma centers eligible for funding under section 1241(b)(3).

"(4) $30,000,000 OR MORE.—If the amount of appropriations for this part in a fiscal year is $30,000,000 or more, the Secretary shall divide such funding evenly among all States.

"SEC. 1282. AUTHORIZATION OF APPROPRIATIONS.

"For the purpose of carrying out this part, there is authorized to be appropriated $100,000,000 for each of fiscal years 2010 through 2015.".

SEC. 3506. PROGRAM TO FACILITATE SHARED DECISION-MAKING.

Part D of title IX of the Public Health Service Act, as amended by section 3503, is further amended by adding at the end the following:

1 **"SEC. 936. PROGRAM TO FACILITATE SHARED DECISION-**
2 **MAKING.**

3 "(a) PURPOSE.—The purpose of this section is to fa-
4 cilitate collaborative processes between patients, caregivers
5 or authorized representatives, and clinicians that engages
6 the patient, caregiver or authorized representative in deci-
7 sionmaking, provides patients, caregivers or authorized
8 representatives with information about trade-offs among
9 treatment options, and facilitates the incorporation of pa-
10 tient preferences and values into the medical plan.

11 "(b) DEFINITIONS.—In this section:

12 "(1) PATIENT DECISION AID.—The term 'pa-
13 tient decision aid' means an educational tool that
14 helps patients, caregivers or authorized representa-
15 tives understand and communicate their beliefs and
16 preferences related to their treatment options, and
17 to decide with their health care provider what treat-
18 ments are best for them based on their treatment
19 options, scientific evidence, circumstances, beliefs,
20 and preferences.

21 "(2) PREFERENCE SENSITIVE CARE.—The term
22 'preference sensitive care' means medical care for
23 which the clinical evidence does not clearly support
24 one treatment option such that the appropriate
25 course of treatment depends on the values of the pa-
26 tient or the preferences of the patient, caregivers or

1 authorized representatives regarding the benefits,
2 harms and scientific evidence for each treatment op-
3 tion, the use of such care should depend on the in-
4 formed patient choice among clinically appropriate
5 treatment options.

6 "(c) ESTABLISHMENT OF INDEPENDENT STANDARDS
7 FOR PATIENT DECISION AIDS FOR PREFERENCE SEN-
8 SITIVE CARE.—

9 "(1) CONTRACT WITH ENTITY TO ESTABLISH
10 STANDARDS AND CERTIFY PATIENT DECISION
11 AIDS.—

12 "(A) IN GENERAL.—For purposes of sup-
13 porting consensus-based standards for patient
14 decision aids for preference sensitive care and a
15 certification process for patient decision aids for
16 use in the Federal health programs and by
17 other interested parties, the Secretary shall
18 have in effect a contract with the entity with a
19 contract under section 1890 of the Social Secu-
20 rity Act. Such contract shall provide that the
21 entity perform the duties described in para-
22 graph (2).

23 "(B) TIMING FOR FIRST CONTRACT.—As
24 soon as practicable after the date of the enact-

1 ment of this section, the Secretary shall enter
2 into the first contract under subparagraph (A).
3 "(C) PERIOD OF CONTRACT.—A contract
4 under subparagraph (A) shall be for a period of
5 18 months (except such contract may be re-
6 newed after a subsequent bidding process).
7 "(2) DUTIES.—The following duties are de-
8 scribed in this paragraph:
9 "(A) DEVELOP AND IDENTIFY STANDARDS
10 FOR PATIENT DECISION AIDS.—The entity shall
11 synthesize evidence and convene a broad range
12 of experts and key stakeholders to develop and
13 identify consensus-based standards to evaluate
14 patient decision aids for preference sensitive
15 care.
16 "(B) ENDORSE PATIENT DECISION AIDS.—
17 The entity shall review patient decision aids
18 and develop a certification process whether pa-
19 tient decision aids meet the standards developed
20 and identified under subparagraph (A). The en-
21 tity shall give priority to the review and certifi-
22 cation of patient decision aids for preference
23 sensitive care.

1 "(d) PROGRAM TO DEVELOP, UPDATE AND PATIENT
2 DECISION AIDS TO ASSIST HEALTH CARE PROVIDERS
3 AND PATIENTS.—
4 "(1) IN GENERAL.—The Secretary, acting
5 through the Director, and in coordination with heads
6 of other relevant agencies, such as the Director of
7 the Centers for Disease Control and Prevention and
8 the Director of the National Institutes of Health,
9 shall establish a program to award grants or con-
10 tracts—
11 "(A) to develop, update, and produce pa-
12 tient decision aids for preference sensitive care
13 to assist health care providers in educating pa-
14 tients, caregivers, and authorized representa-
15 tives concerning the relative safety, relative ef-
16 fectiveness (including possible health outcomes
17 and impact on functional status), and relative
18 cost of treatment or, where appropriate, pallia-
19 tive care options;
20 "(B) to test such materials to ensure such
21 materials are balanced and evidence based in
22 aiding health care providers and patients, care-
23 givers, and authorized representatives to make
24 informed decisions about patient care and can

be easily incorporated into a broad array of practice settings; and

"(C) to educate providers on the use of such materials, including through academic curricula.

"(2) REQUIREMENTS FOR PATIENT DECISION AIDS.—Patient decision aids developed and produced pursuant to a grant or contract under paragraph (1)—

"(A) shall be designed to engage patients, caregivers, and authorized representatives in informed decisionmaking with health care providers;

"(B) shall present up-to-date clinical evidence about the risks and benefits of treatment options in a form and manner that is age-appropriate and can be adapted for patients, caregivers, and authorized representatives from a variety of cultural and educational backgrounds to reflect the varying needs of consumers and diverse levels of health literacy;

"(C) shall, where appropriate, explain why there is a lack of evidence to support one treatment option over another; and

"(D) shall address health care decisions across the age span, including those affecting vulnerable populations including children.

"(3) DISTRIBUTION.—The Director shall ensure that patient decision aids produced with grants or contracts under this section are available to the public.

"(4) NONDUPLICATION OF EFFORTS.—The Director shall ensure that the activities under this section of the Agency and other agencies, including the Centers for Disease Control and Prevention and the National Institutes of Health, are free of unnecessary duplication of effort.

"(e) GRANTS TO SUPPORT SHARED DECISIONMAKING IMPLEMENTATION.—

"(1) IN GENERAL.—The Secretary shall establish a program to provide for the phased-in development, implementation, and evaluation of shared decisionmaking using patient decision aids to meet the objective of improving the understanding of patients of their medical treatment options.

"(2) SHARED DECISIONMAKING RESOURCE CENTERS.—

"(A) IN GENERAL.—The Secretary shall provide grants for the establishment and sup-

1 port of Shared Decisionmaking Resource Cen-
2 ters (referred to in this subsection as 'Centers')
3 to provide technical assistance to providers and
4 to develop and disseminate best practices and
5 other information to support and accelerate
6 adoption, implementation, and effective use of
7 patient decision aids and shared decisionmaking
8 by providers.

9 "(B) OBJECTIVES.—The objective of a
10 Center is to enhance and promote the adoption
11 of patient decision aids and shared decision-
12 making through—

13 "(i) providing assistance to eligible
14 providers with the implementation and ef-
15 fective use of, and training on, patient de-
16 cision aids; and

17 "(ii) the dissemination of best prac-
18 tices and research on the implementation
19 and effective use of patient decision aids.

20 "(3) SHARED DECISIONMAKING PARTICIPATION
21 GRANTS.—

22 "(A) IN GENERAL.—The Secretary shall
23 provide grants to health care providers for the
24 development and implementation of shared deci-

sionmaking techniques and to assess the use of such techniques.

"(B) PREFERENCE.—In order to facilitate the use of best practices, the Secretary shall provide a preference in making grants under this subsection to health care providers who participate in training by Shared Decision-making Resource Centers or comparable training.

"(C) LIMITATION.—Funds under this paragraph shall not be used to purchase or implement use of patient decision aids other than those certified under the process identified in subsection (c).

"(4) GUIDANCE.—The Secretary may issue guidance to eligible grantees under this subsection on the use of patient decision aids.

"(f) FUNDING.—For purposes of carrying out this section there are authorized to be appropriated such sums as may be necessary for fiscal year 2010 and each subsequent fiscal year.".

SEC. 3507. PRESENTATION OF PRESCRIPTION DRUG BENEFIT AND RISK INFORMATION.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the "Sec-

1 retary''), acting through the Commissioner of Food and
2 Drugs, shall determine whether the addition of quan-
3 titative summaries of the benefits and risks of prescription
4 drugs in a standardized format (such as a table or drug
5 facts box) to the promotional labeling or print advertising
6 of such drugs would improve health care decisionmaking
7 by clinicians and patients and consumers.

8 (b) REVIEW AND CONSULTATION.—In making the
9 determination under subsection (a), the Secretary shall re-
10 view all available scientific evidence and research on deci-
11 sionmaking and social and cognitive psychology and con-
12 sult with drug manufacturers, clinicians, patients and con-
13 sumers, experts in health literacy, representatives of racial
14 and ethnic minorities, and experts in women's and pedi-
15 atric health.

16 (c) REPORT.—Not later than 1 year after the date
17 of enactment of this Act, the Secretary shall submit to
18 Congress a report that provides—

19 (1) the determination by the Secretary under
20 subsection (a); and

21 (2) the reasoning and analysis underlying that
22 determination.

23 (d) AUTHORITY.—If the Secretary determines under
24 subsection (a) that the addition of quantitative summaries
25 of the benefits and risks of prescription drugs in a stand-

1 ardized format (such as a table or drug facts box) to the
2 promotional labeling or print advertising of such drugs
3 would improve health care decisionmaking by clinicians
4 and patients and consumers, then the Secretary, not later
5 than 3 years after the date of submission of the report
6 under subsection (c), shall promulgate proposed regula-
7 tions as necessary to implement such format.

8 (e) CLARIFICATION.—Nothing in this section shall be
9 construed to restrict the existing authorities of the Sec-
10 retary with respect to benefit and risk information.

11 **SEC. 3508. DEMONSTRATION PROGRAM TO INTEGRATE**
12 **QUALITY IMPROVEMENT AND PATIENT SAFE-**
13 **TY TRAINING INTO CLINICAL EDUCATION OF**
14 **HEALTH PROFESSIONALS.**

15 (a) IN GENERAL.—The Secretary may award grants
16 to eligible entities or consortia under this section to carry
17 out demonstration projects to develop and implement aca-
18 demic curricula that integrates quality improvement and
19 patient safety in the clinical education of health profes-
20 sionals. Such awards shall be made on a competitive basis
21 and pursuant to peer review.

22 (b) ELIGIBILITY.—To be eligible to receive a grant
23 under subsection (a), an entity or consortium shall—

(1) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require;

(2) be or include—

(A) a health professions school;

(B) a school of public health;

(C) a school of social work;

(D) a school of nursing;

(E) a school of pharmacy;

(F) an institution with a graduate medical education program; or

(G) a school of health care administration;

(3) collaborate in the development of curricula described in subsection (a) with an organization that accredits such school or institution;

(4) provide for the collection of data regarding the effectiveness of the demonstration project; and

(5) provide matching funds in accordance with subsection (c).

(c) MATCHING FUNDS.—

(1) IN GENERAL.—The Secretary may award a grant to an entity or consortium under this section only if the entity or consortium agrees to make available non-Federal contributions toward the costs of the program to be funded under the grant in an

amount that is not less than $1 for each $5 of Federal funds provided under the grant.

(2) DETERMINATION OF AMOUNT CONTRIBUTED.—Non-Federal contributions under paragraph (1) may be in cash or in-kind, fairly evaluated, including equipment or services. Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such contributions.

(d) EVALUATION.—The Secretary shall take such action as may be necessary to evaluate the projects funded under this section and publish, make publicly available, and disseminate the results of such evaluations on as wide a basis as is practicable.

(e) REPORTS.—Not later than 2 years after the date of enactment of this section, and annually thereafter, the Secretary shall submit to the Committee on Health, Education, Labor, and Pensions and the Committee on Finance of the Senate and the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives a report that—

(1) describes the specific projects supported under this section; and

(2) contains recommendations for Congress based on the evaluation conducted under subsection (d).

SEC. 3509. IMPROVING WOMEN'S HEALTH.

(a) HEALTH AND HUMAN SERVICES OFFICE ON WOMEN'S HEALTH.—

(1) ESTABLISHMENT.—Part A of title II of the Public Health Service Act (42 U.S.C. 202 et seq.) is amended by adding at the end the following:

"SEC. 229. HEALTH AND HUMAN SERVICES OFFICE ON WOMEN'S HEALTH.

''(a) ESTABLISHMENT OF OFFICE.—There is established within the Office of the Secretary, an Office on Women's Health (referred to in this section as the 'Office'). The Office shall be headed by a Deputy Assistant Secretary for Women's Health who may report to the Secretary.

''(b) DUTIES.—The Secretary, acting through the Office, with respect to the health concerns of women, shall—

''(1) establish short-range and long-range goals and objectives within the Department of Health and Human Services and, as relevant and appropriate, coordinate with other appropriate offices on activities within the Department that relate to disease prevention, health promotion, service delivery, re-

search, and public and health care professional education, for issues of particular concern to women throughout their lifespan;

"(2) provide expert advice and consultation to the Secretary concerning scientific, legal, ethical, and policy issues relating to women's health;

"(3) monitor the Department of Health and Human Services' offices, agencies, and regional activities regarding women's health and identify needs regarding the coordination of activities, including intramural and extramural multidisciplinary activities;

"(4) establish a Department of Health and Human Services Coordinating Committee on Women's Health, which shall be chaired by the Deputy Assistant Secretary for Women's Health and composed of senior level representatives from each of the agencies and offices of the Department of Health and Human Services;

"(5) establish a National Women's Health Information Center to—

"(A) facilitate the exchange of information regarding matters relating to health information, health promotion, preventive health services, research advances, and education in the appropriate use of health care;

"(B) facilitate access to such information;

"(C) assist in the analysis of issues and problems relating to the matters described in this paragraph; and

"(D) provide technical assistance with respect to the exchange of information (including facilitating the development of materials for such technical assistance);

"(6) coordinate efforts to promote women's health programs and policies with the private sector; and

"(7) through publications and any other means appropriate, provide for the exchange of information between the Office and recipients of grants, contracts, and agreements under subsection (c), and between the Office and health professionals and the general public.

"(c) GRANTS AND CONTRACTS REGARDING DUTIES.—

"(1) AUTHORITY.—In carrying out subsection (b), the Secretary may make grants to, and enter into cooperative agreements, contracts, and interagency agreements with, public and private entities, agencies, and organizations.

1 "(2) EVALUATION AND DISSEMINATION.—The
2 Secretary shall directly or through contracts with
3 public and private entities, agencies, and organiza-
4 tions, provide for evaluations of projects carried out
5 with financial assistance provided under paragraph
6 (1) and for the dissemination of information devel-
7 oped as a result of such projects.
8 "(d) REPORTS.—Not later than 1 year after the date
9 of enactment of this section, and every second year there-
10 after, the Secretary shall prepare and submit to the appro-
11 priate committees of Congress a report describing the ac-
12 tivities carried out under this section during the period
13 for which the report is being prepared.
14 "(e) AUTHORIZATION OF APPROPRIATIONS.—For the
15 purpose of carrying out this section, there are authorized
16 to be appropriated such sums as may be necessary for
17 each of the fiscal years 2010 through 2014.".
18 (2) TRANSFER OF FUNCTIONS.—There are
19 transferred to the Office on Women's Health (estab-
20 lished under section 229 of the Public Health Serv-
21 ice Act, as added by this section), all functions exer-
22 cised by the Office on Women's Health of the Public
23 Health Service prior to the date of enactment of this
24 section, including all personnel and compensation
25 authority, all delegation and assignment authority,

and all remaining appropriations. All orders, determinations, rules, regulations, permits, agreements, grants, contracts, certificates, licenses, registrations, privileges, and other administrative actions that—

(A) have been issued, made, granted, or allowed to become effective by the President, any Federal agency or official thereof, or by a court of competent jurisdiction, in the performance of functions transferred under this paragraph; and

(B) are in effect at the time this section takes effect, or were final before the date of enactment of this section and are to become effective on or after such date,

shall continue in effect according to their terms until modified, terminated, superseded, set aside, or revoked in accordance with law by the President, the Secretary, or other authorized official, a court of competent jurisdiction, or by operation of law.

(b) CENTERS FOR DISEASE CONTROL AND PREVENTION OFFICE OF WOMEN'S HEALTH.—Part A of title III of the Public Health Service Act (42 U.S.C. 241 et seq.) is amended by adding at the end the following:

"SEC. 310A. CENTERS FOR DISEASE CONTROL AND PREVENTION OFFICE OF WOMEN'S HEALTH.

''(a) ESTABLISHMENT.—There is established within the Office of the Director of the Centers for Disease Control and Prevention, an office to be known as the Office of Women's Health (referred to in this section as the 'Office'). The Office shall be headed by a director who shall be appointed by the Director of such Centers.

''(b) PURPOSE.—The Director of the Office shall—

''(1) report to the Director of the Centers for Disease Control and Prevention on the current level of the Centers' activity regarding women's health conditions across, where appropriate, age, biological, and sociocultural contexts, in all aspects of the Centers' work, including prevention programs, public and professional education, services, and treatment;

''(2) establish short-range and long-range goals and objectives within the Centers for women's health and, as relevant and appropriate, coordinate with other appropriate offices on activities within the Centers that relate to prevention, research, education and training, service delivery, and policy development, for issues of particular concern to women;

''(3) identify projects in women's health that should be conducted or supported by the Centers;

1 ''(4) consult with health professionals, non-
2 governmental organizations, consumer organizations,
3 women's health professionals, and other individuals
4 and groups, as appropriate, on the policy of the Cen-
5 ters with regard to women; and
6 ''(5) serve as a member of the Department of
7 Health and Human Services Coordinating Com-
8 mittee on Women's Health (established under sec-
9 tion 229(b)(4)).
10 ''(c) DEFINITION.—As used in this section, the term
11 'women's health conditions', with respect to women of all
12 age, ethnic, and racial groups, means diseases, disorders,
13 and conditions—
14 ''(1) unique to, significantly more serious for,
15 or significantly more prevalent in women; and
16 ''(2) for which the factors of medical risk or
17 type of medical intervention are different for women,
18 or for which there is reasonable evidence that indi-
19 cates that such factors or types may be different for
20 women.
21 ''(d) AUTHORIZATION OF APPROPRIATIONS.—For the
22 purpose of carrying out this section, there are authorized
23 to be appropriated such sums as may be necessary for
24 each of the fiscal years 2010 through 2014.''.

(c) OFFICE OF WOMEN'S HEALTH RESEARCH.—Section 486(a) of the Public Health Service Act (42 U.S.C. 287d(a)) is amended by inserting ''and who shall report directly to the Director'' before the period at the end thereof.

(d) SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION.—Section 501(f) of the Public Health Service Act (42 U.S.C. 290aa(f)) is amended—

(1) in paragraph (1), by inserting ''who shall report directly to the Administrator'' before the period;

(2) by redesignating paragraph (4) as paragraph (5); and

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

''(4) OFFICE.—Nothing in this subsection shall be construed to preclude the Secretary from establishing within the Substance Abuse and Mental Health Administration an Office of Women's Health.''.

(e) AGENCY FOR HEALTHCARE RESEARCH AND QUALITY ACTIVITIES REGARDING WOMEN'S HEALTH.—Part C of title IX of the Public Health Service Act (42 U.S.C. 299c et seq.) is amended—

(1) by redesignating sections 925 and 926 as sections 926 and 927, respectively; and

(2) by inserting after section 924 the following:

"SEC. 925. ACTIVITIES REGARDING WOMEN'S HEALTH.

"(a) ESTABLISHMENT.—There is established within the Office of the Director, an Office of Women's Health and Gender-Based Research (referred to in this section as the 'Office'). The Office shall be headed by a director who shall be appointed by the Director of Healthcare and Research Quality.

"(b) PURPOSE.—The official designated under subsection (a) shall—

"(1) report to the Director on the current Agency level of activity regarding women's health, across, where appropriate, age, biological, and sociocultural contexts, in all aspects of Agency work, including the development of evidence reports and clinical practice protocols and the conduct of research into patient outcomes, delivery of health care services, quality of care, and access to health care;

"(2) establish short-range and long-range goals and objectives within the Agency for research important to women's health and, as relevant and appropriate, coordinate with other appropriate offices on activities within the Agency that relate to health

1 services and medical effectiveness research, for
2 issues of particular concern to women;
3 ''(3) identify projects in women's health that
4 should be conducted or supported by the Agency;
5 ''(4) consult with health professionals, non-
6 governmental organizations, consumer organizations,
7 women's health professionals, and other individuals
8 and groups, as appropriate, on Agency policy with
9 regard to women; and
10 ''(5) serve as a member of the Department of
11 Health and Human Services Coordinating Com-
12 mittee on Women's Health (established under sec-
13 tion 229(b)(4)).''.
14 ''(c) AUTHORIZATION OF APPROPRIATIONS.—For the
15 purpose of carrying out this section, there are authorized
16 to be appropriated such sums as may be necessary for
17 each of the fiscal years 2010 through 2014.''.
18 (f) HEALTH RESOURCES AND SERVICES ADMINIS-
19 TRATION OFFICE OF WOMEN'S HEALTH.—Title VII of
20 the Social Security Act (42 U.S.C. 901 et seq.) is amended
21 by adding at the end the following:
22 **''SEC. 713. OFFICE OF WOMEN'S HEALTH.**
23 ''(a) ESTABLISHMENT.—The Secretary shall estab-
24 lish within the Office of the Administrator of the Health
25 Resources and Services Administration, an office to be

1 known as the Office of Women's Health. The Office shall
2 be headed by a director who shall be appointed by the Ad-
3 ministrator.

4 "(b) PURPOSE.—The Director of the Office shall—

5 "(1) report to the Administrator on the current
6 Administration level of activity regarding women's
7 health across, where appropriate, age, biological, and
8 sociocultural contexts;

9 "(2) establish short-range and long-range goals
10 and objectives within the Health Resources and
11 Services Administration for women's health and, as
12 relevant and appropriate, coordinate with other ap-
13 propriate offices on activities within the Administra-
14 tion that relate to health care provider training,
15 health service delivery, research, and demonstration
16 projects, for issues of particular concern to women;

17 "(3) identify projects in women's health that
18 should be conducted or supported by the bureaus of
19 the Administration;

20 "(4) consult with health professionals, non-
21 governmental organizations, consumer organizations,
22 women's health professionals, and other individuals
23 and groups, as appropriate, on Administration policy
24 with regard to women; and

"(5) serve as a member of the Department of Health and Human Services Coordinating Committee on Women's Health (established under section 229(b)(4) of the Public Health Service Act).

"(c) CONTINUED ADMINISTRATION OF EXISTING PROGRAMS.—The Director of the Office shall assume the authority for the development, implementation, administration, and evaluation of any projects carried out through the Health Resources and Services Administration relating to women's health on the date of enactment of this section.

"(d) DEFINITIONS.—For purposes of this section:

"(1) ADMINISTRATION.—The term 'Administration' means the Health Resources and Services Administration.

"(2) ADMINISTRATOR.—The term 'Administrator' means the Administrator of the Health Resources and Services Administration.

"(3) OFFICE.—The term 'Office' means the Office of Women's Health established under this section in the Administration.

"(e) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2010 through 2014.".

1 (g) FOOD AND DRUG ADMINISTRATION OFFICE OF
2 WOMEN'S HEALTH.—Chapter X of the Federal Food,
3 Drug, and Cosmetic Act (21 U.S.C. 391 et seq.) is amend-
4 ed by adding at the end the following:

5 **"SEC. 1011. OFFICE OF WOMEN'S HEALTH.**

6 "(a) ESTABLISHMENT.—There is established within
7 the Office of the Commissioner, an office to be known as
8 the Office of Women's Health (referred to in this section
9 as the 'Office'). The Office shall be headed by a director
10 who shall be appointed by the Commissioner of Food and
11 Drugs.

12 "(b) PURPOSE.—The Director of the Office shall—

13 "(1) report to the Commissioner of Food and
14 Drugs on current Food and Drug Administration
15 (referred to in this section as the 'Administration')
16 levels of activity regarding women's participation in
17 clinical trials and the analysis of data by sex in the
18 testing of drugs, medical devices, and biological
19 products across, where appropriate, age, biological,
20 and sociocultural contexts;

21 "(2) establish short-range and long-range goals
22 and objectives within the Administration for issues
23 of particular concern to women's health within the
24 jurisdiction of the Administration, including, where
25 relevant and appropriate, adequate inclusion of

1 women and analysis of data by sex in Administration
2 protocols and policies;
3 ''(3) provide information to women and health
4 care providers on those areas in which differences
5 between men and women exist;
6 ''(4) consult with pharmaceutical, biologics, and
7 device manufacturers, health professionals with ex-
8 pertise in women's issues, consumer organizations,
9 and women's health professionals on Administration
10 policy with regard to women;
11 ''(5) make annual estimates of funds needed to
12 monitor clinical trials and analysis of data by sex in
13 accordance with needs that are identified; and
14 ''(6) serve as a member of the Department of
15 Health and Human Services Coordinating Com-
16 mittee on Women's Health (established under sec-
17 tion 229(b)(4) of the Public Health Service Act).
18 ''(c) AUTHORIZATION OF APPROPRIATIONS.—For the
19 purpose of carrying out this section, there are authorized
20 to be appropriated such sums as may be necessary for
21 each of the fiscal years 2010 through 2014.''.
22 (h) NO NEW REGULATORY AUTHORITY.—Nothing in
23 this section and the amendments made by this section may
24 be construed as establishing regulatory authority or modi-
25 fying any existing regulatory authority.

(i) LIMITATION ON TERMINATION.—Notwithstanding any other provision of law, a Federal office of women's health (including the Office of Research on Women's Health of the National Institutes of Health) or Federal appointive position with primary responsibility over women's health issues (including the Associate Administrator for Women's Services under the Substance Abuse and Mental Health Services Administration) that is in existence on the date of enactment of this section shall not be terminated, reorganized, or have any of it's powers or duties transferred unless such termination, reorganization, or transfer is approved by Congress through the adoption of a concurrent resolution of approval.

(j) RULE OF CONSTRUCTION.—Nothing in this section (or the amendments made by this section) shall be construed to limit the authority of the Secretary of Health and Human Services with respect to women's health, or with respect to activities carried out through the Department of Health and Human Services on the date of enactment of this section.

SEC. 3510. PATIENT NAVIGATOR PROGRAM.

Section 340A of the Public Health Service Act (42 U.S.C. 256a) is amended—

(1) by striking subsection (d)(3) and inserting the following:

"(3) LIMITATIONS ON GRANT PERIOD.—In carrying out this section, the Secretary shall ensure that the total period of a grant does not exceed 4 years.";

(2) in subsection (e), by adding at the end the following:

"(3) MINIMUM CORE PROFICIENCIES.—The Secretary shall not award a grant to an entity under this section unless such entity provides assurances that patient navigators recruited, assigned, trained, or employed using grant funds meet minimum core proficiencies, as defined by the entity that submits the application, that are tailored for the main focus or intervention of the navigator involved."; and

(3) in subsection (m)—

(A) in paragraph (1), by striking "and $3,500,000 for fiscal year 2010." and inserting "$3,500,000 for fiscal year 2010, and such sums as may be necessary for each of fiscal years 2011 through 2015."; and

(B) in paragraph (2), by striking "2010" and inserting "2015".

SEC. 3511. AUTHORIZATION OF APPROPRIATIONS.

Except where otherwise provided in this subtitle (or an amendment made by this subtitle), there is authorized

to be appropriated such sums as may be necessary to carry out this subtitle (and such amendments made by this subtitle).

TITLE IV—PREVENTION OF CHRONIC DISEASE AND IMPROVING PUBLIC HEALTH

Subtitle A—Modernizing Disease Prevention and Public Health Systems

SEC. 4001. NATIONAL PREVENTION, HEALTH PROMOTION AND PUBLIC HEALTH COUNCIL.

(a) ESTABLISHMENT.—The President shall establish, within the Department of Health and Human Services, a council to be known as the ''National Prevention, Health Promotion and Public Health Council'' (referred to in this section as the ''Council'').

(b) CHAIRPERSON.—The President shall appoint the Surgeon General to serve as the chairperson of the Council.

(c) COMPOSITION.—The Council shall be composed of—

(1) the Secretary of Health and Human Services;

(2) the Secretary of Agriculture;

(3) the Secretary of Education;

(4) the Chairman of the Federal Trade Commission;

(5) the Secretary of Transportation;

(6) the Secretary of Labor;

(7) the Secretary of Homeland Security;

(8) the Administrator of the Environmental Protection Agency;

(9) the Director of the Office of National Drug Control Policy;

(10) the Director of the Domestic Policy Council;

(11) the Assistant Secretary for Indian Affairs;

(12) the Chairman of the Corporation for National and Community Service; and

(13) the head of any other Federal agency that the chairperson determines is appropriate.

(d) PURPOSES AND DUTIES.—The Council shall—

(1) provide coordination and leadership at the Federal level, and among all Federal departments and agencies, with respect to prevention, wellness and health promotion practices, the public health system, and integrative health care in the United States;

(2) after obtaining input from relevant stakeholders, develop a national prevention, health pro-

1 motion, public health, and integrative health care
2 strategy that incorporates the most effective and
3 achievable means of improving the health status of
4 Americans and reducing the incidence of preventable
5 illness and disability in the United States;

6 (3) provide recommendations to the President
7 and Congress concerning the most pressing health
8 issues confronting the United States and changes in
9 Federal policy to achieve national wellness, health
10 promotion, and public health goals, including the re-
11 duction of tobacco use, sedentary behavior, and poor
12 nutrition;

13 (4) consider and propose evidence-based models,
14 policies, and innovative approaches for the pro-
15 motion of transformative models of prevention, inte-
16 grative health, and public health on individual and
17 community levels across the United States;

18 (5) establish processes for continual public
19 input, including input from State, regional, and local
20 leadership communities and other relevant stake-
21 holders, including Indian tribes and tribal organiza-
22 tions;

23 (6) submit the reports required under sub-
24 section (g); and

(7) carry out other activities determined appropriate by the President.

(e) MEETINGS.—The Council shall meet at the call of the Chairperson.

(f) ADVISORY GROUP.—

(1) IN GENERAL.—The President shall establish an Advisory Group to the Council to be known as the ''Advisory Group on Prevention, Health Promotion, and Integrative and Public Health'' (hereafter referred to in this section as the ''Advisory Group''). The Advisory Group shall be within the Department of Health and Human Services and report to the Surgeon General.

(2) COMPOSITION.—

(A) IN GENERAL.—The Advisory Group shall be composed of not more than 25 non-Federal members to be appointed by the President.

(B) REPRESENTATION.—In appointing members under subparagraph (A), the President shall ensure that the Advisory Group includes a diverse group of licensed health professionals, including integrative health practitioners who have expertise in—

(i) worksite health promotion;

(ii) community services, including community health centers;

(iii) preventive medicine;

(iv) health coaching;

(v) public health education;

(vi) geriatrics; and

(vii) rehabilitation medicine.

(3) PURPOSES AND DUTIES.—The Advisory Group shall develop policy and program recommendations and advise the Council on lifestyle-based chronic disease prevention and management, integrative health care practices, and health promotion.

(g) NATIONAL PREVENTION AND HEALTH PROMOTION STRATEGY.—Not later than 1 year after the date of enactment of this Act, the Chairperson, in consultation with the Council, shall develop and make public a national prevention, health promotion and public health strategy, and shall review and revise such strategy periodically. Such strategy shall—

(1) set specific goals and objectives for improving the health of the United States through federally-supported prevention, health promotion, and public health programs, consistent with ongoing goal setting efforts conducted by specific agencies;

(2) establish specific and measurable actions and timelines to carry out the strategy, and determine accountability for meeting those timelines, within and across Federal departments and agencies; and

(3) make recommendations to improve Federal efforts relating to prevention, health promotion, public health, and integrative health care practices to ensure Federal efforts are consistent with available standards and evidence.

(h) REPORT.—Not later than July 1, 2010, and annually thereafter through January 1, 2015, the Council shall submit to the President and the relevant committees of Congress, a report that—

(1) describes the activities and efforts on prevention, health promotion, and public health and activities to develop a national strategy conducted by the Council during the period for which the report is prepared;

(2) describes the national progress in meeting specific prevention, health promotion, and public health goals defined in the strategy and further describes corrective actions recommended by the Council and taken by relevant agencies and organizations to meet these goals;

(3) contains a list of national priorities on health promotion and disease prevention to address lifestyle behavior modification (smoking cessation, proper nutrition, appropriate exercise, mental health, behavioral health, substance use disorder, and domestic violence screenings) and the prevention measures for the 5 leading disease killers in the United States;

(4) contains specific science-based initiatives to achieve the measurable goals of Healthy People 2010 regarding nutrition, exercise, and smoking cessation, and targeting the 5 leading disease killers in the United States;

(5) contains specific plans for consolidating Federal health programs and Centers that exist to promote healthy behavior and reduce disease risk (including eliminating programs and offices determined to be ineffective in meeting the priority goals of Healthy People 2010);

(6) contains specific plans to ensure that all Federal health care programs are fully coordinated with science-based prevention recommendations by the Director of the Centers for Disease Control and Prevention; and

1 (7) contains specific plans to ensure that all
2 non-Department of Health and Human Services pre-
3 vention programs are based on the science-based
4 guidelines developed by the Centers for Disease Con-
5 trol and Prevention under paragraph (4).

6 (i) PERIODIC REVIEWS.—The Secretary and the
7 Comptroller General of the United States shall jointly con-
8 duct periodic reviews, not less than every 5 years, and
9 evaluations of every Federal disease prevention and health
10 promotion initiative, program, and agency. Such reviews
11 shall be evaluated based on effectiveness in meeting
12 metrics-based goals with an analysis posted on such agen-
13 cies' public Internet websites.

14 **SEC. 4002. PREVENTION AND PUBLIC HEALTH FUND.**

15 (a) PURPOSE.—It is the purpose of this section to
16 establish a Prevention and Public Health Fund (referred
17 to in this section as the ''Fund''), to be administered
18 through the Department of Health and Human Services,
19 Office of the Secretary, to provide for expanded and sus-
20 tained national investment in prevention and public health
21 programs to improve health and help restrain the rate of
22 growth in private and public sector health care costs.

23 (b) FUNDING.—There are hereby authorized to be
24 appropriated, and appropriated, to the Fund, out of any
25 monies in the Treasury not otherwise appropriated—

1 (1) for fiscal year 2010, $500,000,000;
2 (2) for fiscal year 2011, $750,000,000;
3 (3) for fiscal year 2012, $1,000,000,000;
4 (4) for fiscal year 2013, $1,250,000,000;
5 (5) for fiscal year 2014, $1,500,000,000; and
6 (6) for fiscal year 2015, and each fiscal year
7 thereafter, $2,000,000,000.
8 (c) USE OF FUND.—The Secretary shall transfer
9 amounts in the Fund to accounts within the Department
10 of Health and Human Services to increase funding, over
11 the fiscal year 2008 level, for programs authorized by the
12 Public Health Service Act, for prevention, wellness, and
13 public health activities including prevention research and
14 health screenings, such as the Community Transformation
15 grant program, the Education and Outreach Campaign for
16 Preventive Benefits, and immunization programs.
17 (d) TRANSFER AUTHORITY .—The Committee on Ap-
18 propriations of the Senate and the Committee on Appro-
19 priations of the House of Representatives may provide for
20 the transfer of funds in the Fund to eligible activities
21 under this section, subject to subsection (c).
22 **SEC. 4003. CLINICAL AND COMMUNITY PREVENTIVE SERV-**
23 **ICES.**
24 (a) PREVENTIVE SERVICES TASK FORCE.—Section
25 915 of the Public Health Service Act (42 U.S.C. 299b-

1 4) is amended by striking subsection (a) and inserting the
2 following:
3 "(a) PREVENTIVE SERVICES TASK FORCE.—
4 "(1) ESTABLISHMENT AND PURPOSE.—The Di-
5 rector shall convene an independent Preventive Serv-
6 ices Task Force (referred to in this subsection as the
7 'Task Force') to be composed of individuals with ap-
8 propriate expertise. Such Task Force shall review
9 the scientific evidence related to the effectiveness,
10 appropriateness, and cost-effectiveness of clinical
11 preventive services for the purpose of developing rec-
12 ommendations for the health care community, and
13 updating previous clinical preventive recommenda-
14 tions, to be published in the Guide to Clinical Pre-
15 ventive Services (referred to in this section as the
16 'Guide'), for individuals and organizations delivering
17 clinical services, including primary care profes-
18 sionals, health care systems, professional societies,
19 employers, community organizations, non-profit or-
20 ganizations, Congress and other policy-makers, gov-
21 ernmental public health agencies, health care quality
22 organizations, and organizations developing national
23 health objectives. Such recommendations shall con-
24 sider clinical preventive best practice recommenda-
25 tions from the Agency for Healthcare Research and

1 Quality, the National Institutes of Health, the Cen-
2 ters for Disease Control and Prevention, the Insti-
3 tute of Medicine, specialty medical associations, pa-
4 tient groups, and scientific societies.

5 ''(2) DUTIES.—The duties of the Task Force
6 shall include—

7 ''(A) the development of additional topic
8 areas for new recommendations and interven-
9 tions related to those topic areas, including
10 those related to specific sub-populations and
11 age groups;

12 ''(B) at least once during every 5-year pe-
13 riod, review interventions and update rec-
14 ommendations related to existing topic areas,
15 including new or improved techniques to assess
16 the health effects of interventions;

17 ''(C) improved integration with Federal
18 Government health objectives and related target
19 setting for health improvement;

20 ''(D) the enhanced dissemination of rec-
21 ommendations;

22 ''(E) the provision of technical assistance
23 to those health care professionals, agencies and
24 organizations that request help in implementing
25 the Guide recommendations; and

"(F) the submission of yearly reports to Congress and related agencies identifying gaps in research, such as preventive services that receive an insufficient evidence statement, and recommending priority areas that deserve further examination, including areas related to populations and age groups not adequately addressed by current recommendations.

"(3) ROLE OF AGENCY.—The Agency shall provide ongoing administrative, research, and technical support for the operations of the Task Force, including coordinating and supporting the dissemination of the recommendations of the Task Force, ensuring adequate staff resources, and assistance to those organizations requesting it for implementation of the Guide's recommendations.

"(4) COORDINATION WITH COMMUNITY PREVENTIVE SERVICES TASK FORCE.—The Task Force shall take appropriate steps to coordinate its work with the Community Preventive Services Task Force and the Advisory Committee on Immunization Practices, including the examination of how each task force's recommendations interact at the nexus of clinic and community.

"(5) OPERATION.—Operation. In carrying out the duties under paragraph (2), the Task Force is not subject to the provisions of Appendix 2 of title 5, United States Code.

"(6) INDEPENDENCE.—All members of the Task Force convened under this subsection, and any recommendations made by such members, shall be independent and, to the extent practicable, not subject to political pressure.

"(7) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary for each fiscal year to carry out the activities of the Task Force.".

(b) COMMUNITY PREVENTIVE SERVICES TASK FORCE.—

(1) IN GENERAL.—Part P of title III of the Public Health Service Act, as amended by paragraph (2), is amended by adding at the end the following:

"SEC. 399U. COMMUNITY PREVENTIVE SERVICES TASK FORCE.

"(a) ESTABLISHMENT AND PURPOSE.—The Director of the Centers for Disease Control and Prevention shall convene an independent Community Preventive Services Task Force (referred to in this subsection as the 'Task Force') to be composed of individuals with appropriate ex-

1 pertise. Such Task Force shall review the scientific evi-
2 dence related to the effectiveness, appropriateness, and
3 cost-effectiveness of community preventive interventions
4 for the purpose of developing recommendations, to be pub-
5 lished in the Guide to Community Preventive Services (re-
6 ferred to in this section as the 'Guide'), for individuals
7 and organizations delivering population-based services, in-
8 cluding primary care professionals, health care systems,
9 professional societies, employers, community organiza-
10 tions, non-profit organizations, schools, governmental pub-
11 lic health agencies, Indian tribes, tribal organizations and
12 urban Indian organizations, medical groups, Congress and
13 other policy-makers. Community preventive services in-
14 clude any policies, programs, processes or activities de-
15 signed to affect or otherwise affecting health at the popu-
16 lation level.

17 "(b) DUTIES.—The duties of the Task Force shall
18 include—

19 "(1) the development of additional topic areas
20 for new recommendations and interventions related
21 to those topic areas, including those related to spe-
22 cific populations and age groups, as well as the so-
23 cial, economic and physical environments that can
24 have broad effects on the health and disease of pop-

1 ulations and health disparities among sub-popu-
2 lations and age groups;
3 "(2) at least once during every 5-year period,
4 review interventions and update recommendations
5 related to existing topic areas, including new or im-
6 proved techniques to assess the health effects of
7 interventions, including health impact assessment
8 and population health modeling;
9 "(3) improved integration with Federal Govern-
10 ment health objectives and related target setting for
11 health improvement;
12 "(4) the enhanced dissemination of rec-
13 ommendations;
14 "(5) the provision of technical assistance to
15 those health care professionals, agencies, and organi-
16 zations that request help in implementing the Guide
17 recommendations; and
18 "(6) providing yearly reports to Congress and
19 related agencies identifying gaps in research and
20 recommending priority areas that deserve further ex-
21 amination, including areas related to populations
22 and age groups not adequately addressed by current
23 recommendations.
24 "(c) ROLE OF AGENCY.—The Director shall provide
25 ongoing administrative, research, and technical support

for the operations of the Task Force, including coordinating and supporting the dissemination of the recommendations of the Task Force, ensuring adequate staff resources, and assistance to those organizations requesting it for implementation of Guide recommendations.

"(d) COORDINATION WITH PREVENTIVE SERVICES TASK FORCE.—The Task Force shall take appropriate steps to coordinate its work with the U.S. Preventive Services Task Force and the Advisory Committee on Immunization Practices, including the examination of how each task force's recommendations interact at the nexus of clinic and community.

"(e) OPERATION.—In carrying out the duties under subsection (b), the Task Force shall not be subject to the provisions of Appendix 2 of title 5, United States Code.

"(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary for each fiscal year to carry out the activities of the Task Force.".

(2) TECHNICAL AMENDMENTS.—

(A) Section 399R of the Public Health Service Act (as added by section 2 of the ALS Registry Act (Public Law 110-373; 122 Stat. 4047)) is redesignated as section 399S.

(B) Section 399R of such Act (as added by section 3 of the Prenatally and Postnatally Diagnosed Conditions Awareness Act (Public Law 110–374; 122 Stat. 4051)) is redesignated as section 399T.

SEC. 4004. EDUCATION AND OUTREACH CAMPAIGN REGARDING PREVENTIVE BENEFITS.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall provide for the planning and implementation of a national public–private partnership for a prevention and health promotion outreach and education campaign to raise public awareness of health improvement across the life span. Such campaign shall include the dissemination of information that—

(1) describes the importance of utilizing preventive services to promote wellness, reduce health disparities, and mitigate chronic disease;

(2) promotes the use of preventive services recommended by the United States Preventive Services Task Force and the Community Preventive Services Task Force;

(3) encourages healthy behaviors linked to the prevention of chronic diseases;

(4) explains the preventive services covered under health plans offered through a Gateway;

(5) describes additional preventive care supported by the Centers for Disease Control and Prevention, the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration, the Advisory Committee on Immunization Practices, and other appropriate agencies; and

(6) includes general health promotion information.

(b) CONSULTATION.—In coordinating the campaign under subsection (a), the Secretary shall consult with the Institute of Medicine to provide ongoing advice on evidence-based scientific information for policy, program development, and evaluation.

(c) MEDIA CAMPAIGN.—

(1) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish and implement a national science-based media campaign on health promotion and disease prevention.

(2) REQUIREMENT OF CAMPAIGN.—The campaign implemented under paragraph (1)—

(A) shall be designed to address proper nutrition, regular exercise, smoking cessation, obesity reduction, the 5 leading disease killers in the United States, and secondary prevention through disease screening promotion;

(B) shall be carried out through competitively bid contracts awarded to entities providing for the professional production and design of such campaign;

(C) may include the use of television, radio, Internet, and other commercial marketing venues and may be targeted to specific age groups based on peer-reviewed social research;

(D) shall not be duplicative of any other Federal efforts relating to health promotion and disease prevention; and

(E) may include the use of humor and nationally recognized positive role models.

(3) EVALUATION.—The Secretary shall ensure that the campaign implemented under paragraph (1) is subject to an independent evaluation every 2 years and shall report every 2 years to Congress on the effectiveness of such campaigns towards meeting science-based metrics.

1 (d) WEBSITE.—The Secretary, in consultation with
2 private-sector experts, shall maintain or enter into a con-
3 tract to maintain an Internet website to provide science-
4 based information on guidelines for nutrition, regular ex-
5 ercise, obesity reduction, smoking cessation, and specific
6 chronic disease prevention. Such website shall be designed
7 to provide information to health care providers and con-
8 sumers.

9 (e) DISSEMINATION OF INFORMATION THROUGH
10 PROVIDERS.—The Secretary, acting through the Centers
11 for Disease Control and Prevention, shall develop and im-
12 plement a plan for the dissemination of health promotion
13 and disease prevention information consistent with na-
14 tional priorities, to health care providers who participate
15 in Federal programs, including programs administered by
16 the Indian Health Service, the Department of Veterans
17 Affairs, the Department of Defense, and the Health Re-
18 sources and Services Administration, and Medicare and
19 Medicaid.

20 (f) PERSONALIZED PREVENTION PLANS.—

21 (1) CONTRACT.—The Secretary, acting through
22 the Director of the Centers for Disease Control and
23 Prevention, shall enter into a contract with a quali-
24 fied entity for the development and operation of a

1 Federal Internet website personalized prevention
2 plan tool.
3 (2) USE.—The website developed under para-
4 graph (1) shall be designed to be used as a source
5 of the most up-to-date scientific evidence relating to
6 disease prevention for use by individuals. Such
7 website shall contain a component that enables an
8 individual to determine their disease risk (based on
9 personal health and family history, BMI, and other
10 relevant information) relating to the 5 leading dis-
11 eases in the United States, and obtain personalized
12 suggestions for preventing such diseases.
13 (g) INTERNET PORTAL.—The Secretary shall estab-
14 lish an Internet portal for accessing risk-assessment tools
15 developed and maintained by private and academic enti-
16 ties.
17 (h) PRIORITY FUNDING.—Funding for the activities
18 authorized under this section shall take priority over fund-
19 ing provided through the Centers for Disease Control and
20 Prevention for grants to States and other entities for simi-
21 lar purposes and goals as provided for in this section. Not
22 to exceed $500,000,000 shall be expended on the cam-
23 paigns and activities required under this section.
24 (i) PUBLIC AWARENESS OF PREVENTIVE AND OBE-
25 SITY-RELATED SERVICES.—

1 (1) INFORMATION TO STATES.—The Secretary
2 of Health and Human Services shall provide guid-
3 ance and relevant information to States and health
4 care providers regarding preventive and obesity-re-
5 lated services that are available to Medicaid enroll-
6 ees, including obesity screening and counseling for
7 children and adults.
8 (2) INFORMATION TO ENROLLEES.—Each State
9 shall design a public awareness campaign to educate
10 Medicaid enrollees regarding availability and cov-
11 erage of such services, with the goal of reducing
12 incidences of obesity.
13 (3) REPORT.—Not later than January 1, 2011,
14 and every 3 years thereafter through January 1,
15 2017, the Secretary of Health and Human Services
16 shall report to Congress on the status and effective-
17 ness of efforts under paragraphs (1) and (2), includ-
18 ing summaries of the States' efforts to increase
19 awareness of coverage of obesity-related services.
20 (j) AUTHORIZATION OF APPROPRIATIONS.—There
21 are authorized to be appropriated such sums as may be
22 necessary to carry out this section.

Subtitle B—Increasing Access to Clinical Preventive Services

SEC. 4101. SCHOOL-BASED HEALTH CENTERS.

(a) GRANTS FOR THE ESTABLISHMENT OF SCHOOL-BASED HEALTH CENTERS.—

(1) PROGRAM.—The Secretary of Health and Human Services (in this subsection referred to as the ''Secretary'') shall establish a program to award grants to eligible entities to support the operation of school-based health centers.

(2) ELIGIBILITY.—To be eligible for a grant under this subsection, an entity shall—

(A) be a school-based health center or a sponsoring facility of a school-based health center; and

(B) submit an application at such time, in such manner, and containing such information as the Secretary may require, including at a minimum an assurance that funds awarded under the grant shall not be used to provide any service that is not authorized or allowed by Federal, State, or local law.

(3) PREFERENCE.—In awarding grants under this section, the Secretary shall give preference to awarding grants for school-based health centers that

1 serve a large population of children eligible for med-
2 ical assistance under the State Medicaid plan under
3 title XIX of the Social Security Act or under a waiv-
4 er of such plan or children eligible for child health
5 assistance under the State child health plan under
6 title XXI of that Act (42 U.S.C. 1397aa et seq.).

7 (4) LIMITATION ON USE OF FUNDS.—An eligi-
8 ble entity shall use funds provided under a grant
9 awarded under this subsection only for expenditures
10 for facilities (including the acquisition or improve-
11 ment of land, or the acquisition, construction, expan-
12 sion, replacement, or other improvement of any
13 building or other facility), equipment, or similar ex-
14 penditures, as specified by the Secretary. No funds
15 provided under a grant awarded under this section
16 shall be used for expenditures for personnel or to
17 provide health services.

18 (5) APPROPRIATIONS.—Out of any funds in the
19 Treasury not otherwise appropriated, there is appro-
20 priated for each of fiscal years 2010 through 2013,
21 $50,000,000 for the purpose of carrying out this
22 subsection. Funds appropriated under this para-
23 graph shall remain available until expended.

24 (6) DEFINITIONS.—In this subsection, the
25 terms ''school-based health center'' and ''sponsoring

1 facility'' have the meanings given those terms in sec-
2 tion 2110(c)(9) of the Social Security Act (42
3 U.S.C. 1397jj(c)(9)).

4 (b) GRANTS FOR THE OPERATION OF SCHOOL-BASED
5 HEALTH CENTERS.—Part Q of title III of the Public
6 Health Service Act (42 U.S.C. 280h et seq.) is amended
7 by adding at the end the following:

8 **"SEC. 399Z–1. SCHOOL-BASED HEALTH CENTERS.**

9 ''(a) DEFINITIONS; ESTABLISHMENT OF CRITERIA.—
10 In this section:

11 ''(1) COMPREHENSIVE PRIMARY HEALTH SERV-
12 ICES.—The term 'comprehensive primary health
13 services' means the core services offered by school-
14 based health centers, which shall include the fol-
15 lowing:

16 ''(A) PHYSICAL.—Comprehensive health
17 assessments, diagnosis, and treatment of minor,
18 acute, and chronic medical conditions, and re-
19 ferrals to, and follow-up for, specialty care and
20 oral health services.

21 ''(B) MENTAL HEALTH.—Mental health
22 and substance use disorder assessments, crisis
23 intervention, counseling, treatment, and referral
24 to a continuum of services including emergency

1 psychiatric care, community support programs,
2 inpatient care, and outpatient programs.
3 "(2) MEDICALLY UNDERSERVED CHILDREN
4 AND ADOLESCENTS.—
5 "(A) IN GENERAL.—The term 'medically
6 underserved children and adolescents' means a
7 population of children and adolescents who are
8 residents of an area designated as a medically
9 underserved area or a health professional short-
10 age area by the Secretary.
11 "(B) CRITERIA.—The Secretary shall pre-
12 scribe criteria for determining the specific
13 shortages of personal health services for medi-
14 cally underserved children and adolescents
15 under subparagraph (A) that shall—
16 "(i) take into account any comments
17 received by the Secretary from the chief
18 executive officer of a State and local offi-
19 cials in a State; and
20 "(ii) include factors indicative of the
21 health status of such children and adoles-
22 cents of an area, including the ability of
23 the residents of such area to pay for health
24 services, the accessibility of such services,
25 the availability of health professionals to

1 such children and adolescents, and other
2 factors as determined appropriate by the
3 Secretary.
4 "(3) SCHOOL-BASED HEALTH CENTER.—The
5 term 'school-based health center' means a health
6 clinic that—
7 "(A) meets the definition of a school-based
8 health center under section 2110(c)(9)(A) of
9 the Social Security Act and is administered by
10 a sponsoring facility (as defined in section
11 2110(c)(9)(B) of the Social Security Act);
12 "(B) provides, at a minimum, comprehen-
13 sive primary health services during school hours
14 to children and adolescents by health profes-
15 sionals in accordance with established stand-
16 ards, community practice, reporting laws, and
17 other State laws, including parental consent
18 and notification laws that are not inconsistent
19 with Federal law; and
20 "(C) does not perform abortion services.
21 "(b) AUTHORITY TO AWARD GRANTS.—The Sec-
22 retary shall award grants for the costs of the operation
23 of school-based health centers (referred to in this section
24 as 'SBHCs') that meet the requirements of this section.

1 "(c) APPLICATIONS.—To be eligible to receive a grant
2 under this section, an entity shall—
3 "(1) be an SBHC (as defined in subsection
4 (a)(3)); and
5 "(2) submit to the Secretary an application at
6 such time, in such manner, and containing—
7 "(A) evidence that the applicant meets all
8 criteria necessary to be designated an SBHC;
9 "(B) evidence of local need for the services
10 to be provided by the SBHC;
11 "(C) an assurance that—
12 "(i) SBHC services will be provided to
13 those children and adolescents for whom
14 parental or guardian consent has been ob-
15 tained in cooperation with Federal, State,
16 and local laws governing health care serv-
17 ice provision to children and adolescents;
18 "(ii) the SBHC has made and will
19 continue to make every reasonable effort to
20 establish and maintain collaborative rela-
21 tionships with other health care providers
22 in the catchment area of the SBHC;
23 "(iii) the SBHC will provide on-site
24 access during the academic day when
25 school is in session and 24-hour coverage

through an on-call system and through its backup health providers to ensure access to services on a year-round basis when the school or the SBHC is closed;

"(iv) the SBHC will be integrated into the school environment and will coordinate health services with school personnel, such as administrators, teachers, nurses, counselors, and support personnel, as well as with other community providers co-located at the school;

"(v) the SBHC sponsoring facility assumes all responsibility for the SBHC administration, operations, and oversight; and

"(vi) the SBHC will comply with Federal, State, and local laws concerning patient privacy and student records, including regulations promulgated under the Health Insurance Portability and Accountability Act of 1996 and section 444 of the General Education Provisions Act; and

"(D) such other information as the Secretary may require.

1 "(d) PREFERENCES AND CONSIDERATION.—In re-
2 viewing applications:
3 "(1) The Secretary may give preference to ap-
4 plicants who demonstrate an ability to serve the fol-
5 lowing:
6 "(A) Communities that have evidenced
7 barriers to primary health care and mental
8 health and substance use disorder prevention
9 services for children and adolescents.
10 "(B) Communities with high per capita
11 numbers of children and adolescents who are
12 uninsured, underinsured, or enrolled in public
13 health insurance programs.
14 "(C) Populations of children and adoles-
15 cents that have historically demonstrated dif-
16 ficulty in accessing health and mental health
17 and substance use disorder prevention services.
18 "(2) The Secretary may give consideration to
19 whether an applicant has received a grant under
20 subsection (a) of section 4101 of the Patient Protec-
21 tion and Affordable Care Act.
22 "(e) WAIVER OF REQUIREMENTS.—The Secretary
23 may—
24 "(1) under appropriate circumstances, waive
25 the application of all or part of the requirements of

this subsection with respect to an SBHC for not to exceed 2 years; and

"(2) upon a showing of good cause, waive the requirement that the SBHC provide all required comprehensive primary health services for a designated period of time to be determined by the Secretary.

"(f) USE OF FUNDS.—

"(1) FUNDS.—Funds awarded under a grant under this section—

"(A) may be used for—

"(i) acquiring and leasing equipment (including the costs of amortizing the principle of, and paying interest on, loans for such equipment);

"(ii) providing training related to the provision of required comprehensive primary health services and additional health services;

"(iii) the management and operation of health center programs;

"(iv) the payment of salaries for physicians, nurses, and other personnel of the SBHC; and

"(B) may not be used to provide abortions.

"(2) CONSTRUCTION.—The Secretary may award grants which may be used to pay the costs associated with expanding and modernizing existing buildings for use as an SBHC, including the purchase of trailers or manufactured buildings to install on the school property.

"(3) LIMITATIONS.—

"(A) IN GENERAL.—Any provider of services that is determined by a State to be in violation of a State law described in subsection (a)(3)(B) with respect to activities carried out at a SBHC shall not be eligible to receive additional funding under this section.

"(B) NO OVERLAPPING GRANT PERIOD.—No entity that has received funding under section 330 for a grant period shall be eligible for a grant under this section for with respect to the same grant period.

"(g) MATCHING REQUIREMENT.—

"(1) IN GENERAL.—Each eligible entity that receives a grant under this section shall provide, from non-Federal sources, an amount equal to 20 percent of the amount of the grant (which may be provided in cash or in-kind) to carry out the activities supported by the grant.

1 "(2) WAIVER.—The Secretary may waive all or
2 part of the matching requirement described in para-
3 graph (1) for any fiscal year for the SBHC if the
4 Secretary determines that applying the matching re-
5 quirement to the SBHC would result in serious
6 hardship or an inability to carry out the purposes of
7 this section.
8 "(h) SUPPLEMENT, NOT SUPPLANT.—Grant funds
9 provided under this section shall be used to supplement,
10 not supplant, other Federal or State funds.
11 "(i) EVALUATION.—The Secretary shall develop and
12 implement a plan for evaluating SBHCs and monitoring
13 quality performance under the awards made under this
14 section.
15 "(j) AGE APPROPRIATE SERVICES.—An eligible enti-
16 ty receiving funds under this section shall only provide age
17 appropriate services through a SBHC funded under this
18 section to an individual.
19 "(k) PARENTAL CONSENT.—An eligible entity receiv-
20 ing funds under this section shall not provide services
21 through a SBHC funded under this section to an indi-
22 vidual without the consent of the parent or guardian of
23 such individual if such individual is considered a minor
24 under applicable State law.

"(l) AUTHORIZATION OF APPROPRIATIONS.—For purposes of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2010 through 2014.".

SEC. 4102. ORAL HEALTHCARE PREVENTION ACTIVITIES.

(a) IN GENERAL.—Title III of the Public Health Service Act (42 U.S.C. 241 et seq.), as amended by section 3025, is amended by adding at the end the following:

"PART T—ORAL HEALTHCARE PREVENTION ACTIVITIES

"SEC. 399LL. ORAL HEALTHCARE PREVENTION EDUCATION CAMPAIGN.

"(a) ESTABLISHMENT.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention and in consultation with professional oral health organizations, shall, subject to the availability of appropriations, establish a 5-year national, public education campaign (referred to in this section as the 'campaign') that is focused on oral healthcare prevention and education, including prevention of oral disease such as early childhood and other caries, periodontal disease, and oral cancer.

"(b) REQUIREMENTS.—In establishing the campaign, the Secretary shall—

"(1) ensure that activities are targeted towards specific populations such as children, pregnant women, parents, the elderly, individuals with disabilities, and ethnic and racial minority populations, including Indians, Alaska Natives and Native Hawaiians (as defined in section 4(c) of the Indian Health Care Improvement Act) in a culturally and linguistically appropriate manner; and

"(2) utilize science-based strategies to convey oral health prevention messages that include, but are not limited to, community water fluoridation and dental sealants.

"(c) PLANNING AND IMPLEMENTATION.—Not later than 2 years after the date of enactment of this section, the Secretary shall begin implementing the 5-year campaign. During the 2-year period referred to in the previous sentence, the Secretary shall conduct planning activities with respect to the campaign.

"SEC. 399LL-1. RESEARCH-BASED DENTAL CARIES DISEASE MANAGEMENT.

"(a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall award demonstration grants to eligible entities to demonstrate the effectiveness of research-based dental caries disease management activities.

1 "(b) ELIGIBILITY.—To be eligible for a grant under
2 this section, an entity shall—
3 "(1) be a community-based provider of dental
4 services (as defined by the Secretary), including a
5 Federally-qualified health center, a clinic of a hos-
6 pital owned or operated by a State (or by an instru-
7 mentality or a unit of government within a State),
8 a State or local department of health, a dental pro-
9 gram of the Indian Health Service, an Indian tribe
10 or tribal organization, or an urban Indian organiza-
11 tion (as such terms are defined in section 4 of the
12 Indian Health Care Improvement Act), a health sys-
13 tem provider, a private provider of dental services,
14 medical, dental, public health, nursing, nutrition
15 educational institutions, or national organizations in-
16 volved in improving children's oral health; and
17 "(2) submit to the Secretary an application at
18 such time, in such manner, and containing such in-
19 formation as the Secretary may require.
20 "(c) USE OF FUNDS.—A grantee shall use amounts
21 received under a grant under this section to demonstrate
22 the effectiveness of research-based dental caries disease
23 management activities.
24 "(d) USE OF INFORMATION.—The Secretary shall
25 utilize information generated from grantees under this

1 section in planning and implementing the public education
2 campaign under section 399LL.

3 **"SEC. 399LL-2. AUTHORIZATION OF APPROPRIATIONS.**

4 "There is authorized to be appropriated to carry out
5 this part, such sums as may be necessary.".

6 (b) SCHOOL-BASED SEALANT PROGRAMS.—Section
7 317M(c)(1) of the Public Health Service Act (42 U.S.C.
8 247b-14(c)(1)) is amended by striking "may award grants
9 to States and Indian tribes" and inserting "shall award
10 a grant to each of the 50 States and territories and to
11 Indians, Indian tribes, tribal organizations and urban In-
12 dian organizations (as such terms are defined in section
13 4 of the Indian Health Care Improvement Act)".

14 (c) ORAL HEALTH INFRASTRUCTURE.—Section
15 317M of the Public Health Service Act (42 U.S.C. 247b-
16 14) is amended—

17 (1) by redesignating subsections (d) and (e) as
18 subsections (e) and (f), respectively; and

19 (2) by inserting after subsection (c), the fol-
20 lowing:

21 "(d) ORAL HEALTH INFRASTRUCTURE.—

22 "(1) COOPERATIVE AGREEMENTS.—The Sec-
23 retary, acting through the Director of the Centers
24 for Disease Control and Prevention, shall enter into
25 cooperative agreements with State, territorial, and

Indian tribes or tribal organizations (as those terms are defined in section 4 of the Indian Health Care Improvement Act) to establish oral health leadership and program guidance, oral health data collection and interpretation, (including determinants of poor oral health among vulnerable populations), a multi-dimensional delivery system for oral health, and to implement science-based programs (including dental sealants and community water fluoridation) to improve oral health.

"(2) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated such sums as necessary to carry out this subsection for fiscal years 2010 through 2014.".

(d) UPDATING NATIONAL ORAL HEALTHCARE SURVEILLANCE ACTIVITIES.—

(1) PRAMS.—

(A) IN GENERAL.—The Secretary of Health and Human Services (referred to in this subsection as the "Secretary") shall carry out activities to update and improve the Pregnancy Risk Assessment Monitoring System (referred to in this section as "PRAMS") as it relates to oral healthcare.

(B) STATE REPORTS AND MANDATORY MEASUREMENTS.—

(i) IN GENERAL.—Not later than 5 years after the date of enactment of this Act, and every 5 years thereafter, a State shall submit to the Secretary a report concerning activities conducted within the State under PRAMS.

(ii) MEASUREMENTS.—The oral healthcare measurements developed by the Secretary for use under PRAMS shall be mandatory with respect to States for purposes of the State reports under clause (i).

(C) FUNDING.—There is authorized to be appropriated to carry out this paragraph, such sums as may be necessary.

(2) NATIONAL HEALTH AND NUTRITION EXAMINATION SURVEY.—The Secretary shall develop oral healthcare components that shall include tooth-level surveillance for inclusion in the National Health and Nutrition Examination Survey. Such components shall be updated by the Secretary at least every 6 years. For purposes of this paragraph, the term ''tooth-level surveillance'' means a clinical examination where an examiner looks at each dental surface,

on each tooth in the mouth and as expanded by the Division of Oral Health of the Centers for Disease Control and Prevention.

(3) MEDICAL EXPENDITURES PANEL SURVEY.—The Secretary shall ensure that the Medical Expenditures Panel Survey by the Agency for Healthcare Research and Quality includes the verification of dental utilization, expenditure, and coverage findings through conduct of a look-back analysis.

(4) NATIONAL ORAL HEALTH SURVEILLANCE SYSTEM.—

(A) APPROPRIATIONS.—There is authorized to be appropriated, such sums as may be necessary for each of fiscal years 2010 through 2014 to increase the participation of States in the National Oral Health Surveillance System from 16 States to all 50 States, territories, and District of Columbia.

(B) REQUIREMENTS.—The Secretary shall ensure that the National Oral Health Surveillance System include the measurement of early childhood caries.

SEC. 4103. MEDICARE COVERAGE OF ANNUAL WELLNESS VISIT PROVIDING A PERSONALIZED PREVENTION PLAN.

(a) COVERAGE OF PERSONALIZED PREVENTION PLAN SERVICES.—

(1) IN GENERAL.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended—

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

(B) in subparagraph (EE), by adding ''and'' at the end; and

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

''(FF) personalized prevention plan services (as defined in subsection (hhh));''.

(2) CONFORMING AMENDMENTS.—Clauses (i) and (ii) of section 1861(s)(2)(K) of the Social Security Act (42 U.S.C. 1395x(s)(2)(K)) are each amended by striking ''subsection (ww)(1)'' and inserting ''subsections (ww)(1) and (hhh)''.

(b) PERSONALIZED PREVENTION PLAN SERVICES DEFINED.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

1 "Annual Wellness Visit

2 "(hhh)(1) The term 'personalized prevention plan
3 services' means the creation of a plan for an individual—

4 "(A) that includes a health risk assessment
5 (that meets the guidelines established by the Sec-
6 retary under paragraph (4)(A)) of the individual
7 that is completed prior to or as part of the same
8 visit with a health professional described in para-
9 graph (3); and

10 "(B) that—

11 "(i) takes into account the results of the
12 health risk assessment; and

13 "(ii) may contain the elements described in
14 paragraph (2).

15 "(2) Subject to paragraph (4)(H), the elements de-
16 scribed in this paragraph are the following:

17 "(A) The establishment of, or an update to, the
18 individual's medical and family history.

19 "(B) A list of current providers and suppliers
20 that are regularly involved in providing medical care
21 to the individual (including a list of all prescribed
22 medications).

23 "(C) A measurement of height, weight, body
24 mass index (or waist circumference, if appropriate),
25 blood pressure, and other routine measurements.

1 "(D) Detection of any cognitive impairment.
2 "(E) The establishment of, or an update to, the
3 following:
4 "(i) A screening schedule for the next 5 to
5 10 years, as appropriate, based on rec-
6 ommendations of the United States Preventive
7 Services Task Force and the Advisory Com-
8 mittee on Immunization Practices, and the indi-
9 vidual's health status, screening history, and
10 age-appropriate preventive services covered
11 under this title.
12 "(ii) A list of risk factors and conditions
13 for which primary, secondary, or tertiary pre-
14 vention interventions are recommended or are
15 underway, including any mental health condi-
16 tions or any such risk factors or conditions that
17 have been identified through an initial preven-
18 tive physical examination (as described under
19 subsection (ww)(1)), and a list of treatment op-
20 tions and their associated risks and benefits.
21 "(F) The furnishing of personalized health ad-
22 vice and a referral, as appropriate, to health edu-
23 cation or preventive counseling services or programs
24 aimed at reducing identified risk factors and improv-
25 ing self-management, or community-based lifestyle

1 interventions to reduce health risks and promote
2 self-management and wellness, including weight loss,
3 physical activity, smoking cessation, fall prevention,
4 and nutrition.
5 ''(G) Any other element determined appropriate
6 by the Secretary.
7 ''(3) A health professional described in this para-
8 graph is—
9 ''(A) a physician;
10 ''(B) a practitioner described in clause (i) of
11 section 1842(b)(18)(C); or
12 ''(C) a medical professional (including a health
13 educator, registered dietitian, or nutrition profes-
14 sional) or a team of medical professionals, as deter-
15 mined appropriate by the Secretary, under the su-
16 pervision of a physician.
17 ''(4)(A) For purposes of paragraph (1)(A), the Sec-
18 retary, not later than 1 year after the date of enactment
19 of this subsection, shall establish publicly available guide-
20 lines for health risk assessments. Such guidelines shall be
21 developed in consultation with relevant groups and entities
22 and shall provide that a health risk assessment—
23 ''(i) identify chronic diseases, injury risks,
24 modifiable risk factors, and urgent health needs of
25 the individual; and

1 "(ii) may be furnished—
2 "(I) through an interactive telephonic or
3 web-based program that meets the standards
4 established under subparagraph (B);
5 "(II) during an encounter with a health
6 care professional;
7 "(III) through community-based preven-
8 tion programs; or
9 "(IV) through any other means the Sec-
10 retary determines appropriate to maximize ac-
11 cessibility and ease of use by beneficiaries, while
12 ensuring the privacy of such beneficiaries.
13 "(B) Not later than 1 year after the date of enact-
14 ment of this subsection, the Secretary shall establish
15 standards for interactive telephonic or web-based pro-
16 grams used to furnish health risk assessments under sub-
17 paragraph (A)(ii)(I). The Secretary may utilize any health
18 risk assessment developed under section 4004(f) of the
19 Patient Protection and Affordable Care Act as part of the
20 requirement to develop a personalized prevention plan to
21 comply with this subparagraph.
22 "(C)(i) Not later than 18 months after the date of
23 enactment of this subsection, the Secretary shall develop
24 and make available to the public a health risk assessment
25 model. Such model shall meet the guidelines under sub-

1 paragraph (A) and may be used to meet the requirement
2 under paragraph (1)(A).
3 "(ii) Any health risk assessment that meets the
4 guidelines under subparagraph (A) and is approved by the
5 Secretary may be used to meet the requirement under
6 paragraph (1)(A).
7 "(D) The Secretary may coordinate with community-
8 based entities (including State Health Insurance Pro-
9 grams, Area Agencies on Aging, Aging and Disability Re-
10 source Centers, and the Administration on Aging) to—
11 "(i) ensure that health risk assessments are ac-
12 cessible to beneficiaries; and
13 "(ii) provide appropriate support for the com-
14 pletion of health risk assessments by beneficiaries.
15 "(E) The Secretary shall establish procedures to
16 make beneficiaries and providers aware of the requirement
17 that a beneficiary complete a health risk assessment prior
18 to or at the same time as receiving personalized prevention
19 plan services.
20 "(F) To the extent practicable, the Secretary shall
21 encourage the use of, integration with, and coordination
22 of health information technology (including use of tech-
23 nology that is compatible with electronic medical records
24 and personal health records) and may experiment with the
25 use of personalized technology to aid in the development

of self-management skills and management of and adherence to provider recommendations in order to improve the health status of beneficiaries.

"(G)(i) A beneficiary shall only be eligible to receive an initial preventive physical examination (as defined under subsection (ww)(1)) at any time during the 12-month period after the date that the beneficiary's coverage begins under part B and shall be eligible to receive personalized prevention plan services under this subsection provided that the beneficiary has not received such services within the preceding 12-month period.

"(ii) The Secretary shall establish procedures to make beneficiaries aware of the option to select an initial preventive physical examination or personalized prevention plan services during the period of 12 months after the date that a beneficiary's coverage begins under part B, which shall include information regarding any relevant differences between such services.

"(H) The Secretary shall issue guidance that—

"(i) identifies elements under paragraph (2) that are required to be provided to a beneficiary as part of their first visit for personalized prevention plan services; and

"(ii) establishes a yearly schedule for appropriate provision of such elements thereafter.".

(c) PAYMENT AND ELIMINATION OF COST-SHARING.—

(1) PAYMENT AND ELIMINATION OF COINSURANCE.—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)) is amended—

(A) in subparagraph (N), by inserting ''other than personalized prevention plan services (as defined in section 1861(hhh)(1))'' after ''(as defined in section 1848(j)(3))'';

(B) by striking ''and'' before ''(W)''; and

(C) by inserting before the semicolon at the end the following: '', and (X) with respect to personalized prevention plan services (as defined in section 1861(hhh)(1)), the amount paid shall be 100 percent of the lesser of the actual charge for the services or the amount determined under the payment basis determined under section 1848''.

(2) PAYMENT UNDER PHYSICIAN FEE SCHEDULE.—Section 1848(j)(3) of the Social Security Act (42 U.S.C. 1395w–4(j)(3)) is amended by inserting ''(2)(FF) (including administration of the health risk assessment) ,'' after ''(2)(EE),''.

(3) ELIMINATION OF COINSURANCE IN OUTPATIENT HOSPITAL SETTINGS.—

(A) EXCLUSION FROM OPD FEE SCHEDULE.—Section 1833(t)(1)(B)(iv) of the Social Security Act (42 U.S.C. 1395l(t)(1)(B)(iv)) is amended by striking ''and diagnostic mammography'' and inserting '', diagnostic mammography, or personalized prevention plan services (as defined in section 1861(hhh)(1))''.

(B) CONFORMING AMENDMENTS.—Section 1833(a)(2) of the Social Security Act (42 U.S.C. 1395l(a)(2)) is amended—

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

(ii) in subparagraph (G)(ii), by striking the comma at the end and inserting ''; and''; and

(iii) by inserting after subparagraph (G)(ii) the following new subparagraph:

''(H) with respect to personalized prevention plan services (as defined in section 1861(hhh)(1)) furnished by an outpatient department of a hospital, the amount determined under paragraph (1)(X),''.

(4) WAIVER OF APPLICATION OF DEDUCTIBLE.—The first sentence of section 1833(b) of the

Social Security Act (42 U.S.C. 1395l(b)) is amended—

(A) by striking ''and'' before ''(9)''; and

(B) by inserting before the period the following: '', and (10) such deductible shall not apply with respect to personalized prevention plan services (as defined in section 1861(hhh)(1))''.

(d) FREQUENCY LIMITATION.—Section 1862(a) of the Social Security Act (42 U.S.C. 1395y(a)) is amended—

(1) in paragraph (1)—

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

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

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

''(P) in the case of personalized prevention plan services (as defined in section 1861(hhh)(1)), which are performed more frequently than is covered under such section;''; and

(2) in paragraph (7), by striking ''or (K)'' and inserting ''(K), or (P)''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2011.

SEC. 4104. REMOVAL OF BARRIERS TO PREVENTIVE SERVICES IN MEDICARE.

(a) DEFINITION OF PREVENTIVE SERVICES.—Section 1861(ddd) of the Social Security Act (42 U.S.C. 1395x(ddd)) is amended—

(1) in the heading, by inserting "; Preventive Services" after "Services";

(2) in paragraph (1), by striking "not otherwise described in this title" and inserting "not described in subparagraph (A) or (C) of paragraph (3)"; and

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

"(3) The term 'preventive services' means the following:

"(A) The screening and preventive services described in subsection (ww)(2) (other than the service described in subparagraph (M) of such subsection).

"(B) An initial preventive physical examination (as defined in subsection (ww)).

"(C) Personalized prevention plan services (as defined in subsection (hhh)(1)).".

(b) COINSURANCE.—

1 (1) GENERAL APPLICATION.—

2 (A) IN GENERAL.—Section 1833(a)(1) of
3 the Social Security Act (42 U.S.C.
4 1395l(a)(1)), as amended by section 4103(c)(1),
5 is amended—

6 (i) in subparagraph (T), by inserting
7 ''(or 100 percent if such services are rec-
8 ommended with a grade of A or B by the
9 United States Preventive Services Task
10 Force for any indication or population and
11 are appropriate for the individual)'' after
12 ''80 percent'';

13 (ii) in subparagraph (W)—

14 (I) in clause (i), by inserting ''(if
15 such subparagraph were applied, by
16 substituting '100 percent' for '80 per-
17 cent')'' after ''subparagraph (D)'';
18 and

19 (II) in clause (ii), by striking ''80
20 percent'' and inserting ''100 percent'';

21 (iii) by striking ''and'' before ''(X)'';
22 and

23 (iv) by inserting before the semicolon
24 at the end the following: '', and (Y) with
25 respect to preventive services described in

subparagraphs (A) and (B) of section 1861(ddd)(3) that are appropriate for the individual and, in the case of such services described in subparagraph (A), are recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or population, the amount paid shall be 100 percent of the lesser of the actual charge for the services or the amount determined under the fee schedule that applies to such services under this part''.

(2) ELIMINATION OF COINSURANCE IN OUTPATIENT HOSPITAL SETTINGS.—

(A) EXCLUSION FROM OPD FEE SCHEDULE.—Section 1833(t)(1)(B)(iv) of the Social Security Act (42 U.S.C. 1395l(t)(1)(B)(iv)), as amended by section 4103(c)(3)(A), is amended—

(i) by striking ''or'' before ''personalized prevention plan services''; and

(ii) by inserting before the period the following: '', or preventive services described in subparagraphs (A) and (B) of section 1861(ddd)(3) that are appropriate

for the individual and, in the case of such services described in subparagraph (A), are recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or population''.

(B) CONFORMING AMENDMENTS.—Section 1833(a)(2) of the Social Security Act (42 U.S.C. 1395l(a)(2)), as amended by section 4103(c)(3)(B), is amended—

(i) in subparagraph (G)(ii), by striking ''and'' after the semicolon at the end;

(ii) in subparagraph (H), by striking the comma at the end and inserting ''; and''; and

(iii) by inserting after subparagraph (H) the following new subparagraph:

''(I) with respect to preventive services described in subparagraphs (A) and (B) of section 1861(ddd)(3) that are appropriate for the individual and are furnished by an outpatient department of a hospital and, in the case of such services described in subparagraph (A), are recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or population, the amount

determined under paragraph (1)(W) or (1)(Y),''.

(c) WAIVER OF APPLICATION OF DEDUCTIBLE FOR PREVENTIVE SERVICES AND COLORECTAL CANCER SCREENING TESTS.—Section 1833(b) of the Social Security Act (42 U.S.C. 1395l(b)), as amended by section 4103(c)(4), is amended—

(1) in paragraph (1), by striking ''items and services described in section 1861(s)(10)(A)'' and inserting ''preventive services described in subparagraph (A) of section 1861(ddd)(3) that are recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or population and are appropriate for the individual.''; and

(2) by adding at the end the following new sentence: ''Paragraph (1) of the first sentence of this subsection shall apply with respect to a colorectal cancer screening test regardless of the code that is billed for the establishment of a diagnosis as a result of the test, or for the removal of tissue or other matter or other procedure that is furnished in connection with, as a result of, and in the same clinical encounter as the screening test.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 2011.

SEC. 4105. EVIDENCE-BASED COVERAGE OF PREVENTIVE SERVICES IN MEDICARE.

(a) AUTHORITY TO MODIFY OR ELIMINATE COVERAGE OF CERTAIN PREVENTIVE SERVICES.—Section 1834 of the Social Security Act (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

"(n) AUTHORITY TO MODIFY OR ELIMINATE COVERAGE OF CERTAIN PREVENTIVE SERVICES.—Notwithstanding any other provision of this title, effective beginning on January 1, 2010, if the Secretary determines appropriate, the Secretary may—

"(1) modify—

"(A) the coverage of any preventive service described in subparagraph (A) of section 1861(ddd)(3) to the extent that such modification is consistent with the recommendations of the United States Preventive Services Task Force; and

"(B) the services included in the initial preventive physical examination described in subparagraph (B) of such section; and

"(2) provide that no payment shall be made under this title for a preventive service described in subparagraph (A) of such section that has not received a grade of A, B, C, or I by such Task Force.".

(b) CONSTRUCTION.—Nothing in the amendment made by paragraph (1) shall be construed to affect the coverage of diagnostic or treatment services under title XVIII of the Social Security Act.

SEC. 4106. IMPROVING ACCESS TO PREVENTIVE SERVICES FOR ELIGIBLE ADULTS IN MEDICAID.

(a) CLARIFICATION OF INCLUSION OF SERVICES.—Section 1905(a)(13) of the Social Security Act (42 U.S.C. 1396d(a)(13)) is amended to read as follows:

"(13) other diagnostic, screening, preventive, and rehabilitative services, including—

"(A) any clinical preventive services that are assigned a grade of A or B by the United States Preventive Services Task Force;

"(B) with respect to an adult individual, approved vaccines recommended by the Advisory Committee on Immunization Practices (an advisory committee established by the Secretary, acting through the Director of the Cen-

ters for Disease Control and Prevention) and their administration; and

"(C) any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level;".

(b) INCREASED FMAP.—Section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)), as amended by sections 2001(a)(3)(A) and 2004(c)(1), is amended in the first sentence—

(1) by striking ", and (4)" and inserting ", (4)"; and

(2) by inserting before the period the following: ", and (5) in the case of a State that provides medical assistance for services and vaccines described in subparagraphs (A) and (B) of subsection (a)(13), and prohibits cost-sharing for such services and vaccines, the Federal medical assistance percentage, as determined under this subsection and subsection (y) (without regard to paragraph (1)(C) of such subsection), shall be increased by 1 percentage point

with respect to medical assistance for such services and vaccines and for items and services described in subsection (a)(4)(D)''.

(c) EFFECTIVE DATE.—The amendments made under this section shall take effect on January 1, 2013.

SEC. 4107. COVERAGE OF COMPREHENSIVE TOBACCO CESSATION SERVICES FOR PREGNANT WOMEN IN MEDICAID.

(a) REQUIRING COVERAGE OF COUNSELING AND PHARMACOTHERAPY FOR CESSATION OF TOBACCO USE BY PREGNANT WOMEN.—Section 1905 of the Social Security Act (42 U.S.C. 1396d), as amended by sections 2001(a)(3)(B) and 2303, is further amended—

(1) in subsection (a)(4)—

(A) by striking ''and'' before ''(C)''; and

(B) by inserting before the semicolon at the end the following new subparagraph: ''; and (D) counseling and pharmacotherapy for cessation of tobacco use by pregnant women (as defined in subsection (bb))''; and

(2) by adding at the end the following:

''(bb)(1) For purposes of this title, the term 'counseling and pharmacotherapy for cessation of tobacco use by pregnant women' means diagnostic, therapy, and counseling services and pharmacotherapy (including the cov-

1 erage of prescription and nonprescription tobacco ces-
2 sation agents approved by the Food and Drug Administra-
3 tion) for cessation of tobacco use by pregnant women who
4 use tobacco products or who are being treated for tobacco
5 use that is furnished—

6 "(A) by or under the supervision of a physician;
7 or

8 "(B) by any other health care professional
9 who—

10 "(i) is legally authorized to furnish such
11 services under State law (or the State regu-
12 latory mechanism provided by State law) of the
13 State in which the services are furnished; and

14 "(ii) is authorized to receive payment for
15 other services under this title or is designated
16 by the Secretary for this purpose.

17 "(2) Subject to paragraph (3), such term is limited
18 to—

19 "(A) services recommended with respect to
20 pregnant women in 'Treating Tobacco Use and De-
21 pendence: 2008 Update: A Clinical Practice Guide-
22 line', published by the Public Health Service in May
23 2008, or any subsequent modification of such Guide-
24 line; and

"(B) such other services that the Secretary recognizes to be effective for cessation of tobacco use by pregnant women.

"(3) Such term shall not include coverage for drugs or biologicals that are not otherwise covered under this title.".

(b) EXCEPTION FROM OPTIONAL RESTRICTION UNDER MEDICAID PRESCRIPTION DRUG COVERAGE.—Section 1927(d)(2)(F) of the Social Security Act (42 U.S.C. 1396r–8(d)(2)(F)), as redesignated by section 2502(a), is amended by inserting before the period at the end the following: ", except, in the case of pregnant women when recommended in accordance with the Guideline referred to in section 1905(bb)(2)(A), agents approved by the Food and Drug Administration under the over-the-counter monograph process for purposes of promoting, and when used to promote, tobacco cessation".

(c) REMOVAL OF COST-SHARING FOR COUNSELING AND PHARMACOTHERAPY FOR CESSATION OF TOBACCO USE BY PREGNANT WOMEN.—

(1) GENERAL COST-SHARING LIMITATIONS.—Section 1916 of the Social Security Act (42 U.S.C. 1396o) is amended in each of subsections (a)(2)(B) and (b)(2)(B) by inserting ", and counseling and pharmacotherapy for cessation of tobacco use by

1 pregnant women (as defined in section 1905(bb))
2 and covered outpatient drugs (as defined in sub-
3 section (k)(2) of section 1927 and including non-
4 prescription drugs described in subsection (d)(2) of
5 such section) that are prescribed for purposes of
6 promoting, and when used to promote, tobacco ces-
7 sation by pregnant women in accordance with the
8 Guideline referred to in section 1905(bb)(2)(A)''
9 after ''complicate the pregnancy''.

10 (2) APPLICATION TO ALTERNATIVE COST-SHAR-
11 ING.—Section 1916A(b)(3)(B)(iii) of such Act (42
12 U.S.C. 1396o–1(b)(3)(B)(iii)) is amended by insert-
13 ing '', and counseling and pharmacotherapy for ces-
14 sation of tobacco use by pregnant women (as defined
15 in section 1905(bb))'' after ''complicate the preg-
16 nancy''.

17 (d) EFFECTIVE DATE.—The amendments made by
18 this section shall take effect on October 1, 2010.

19 **SEC. 4108. INCENTIVES FOR PREVENTION OF CHRONIC DIS-**
20 **EASES IN MEDICAID.**

21 (a) INITIATIVES.—

22 (1) ESTABLISHMENT.—

23 (A) IN GENERAL.—The Secretary shall
24 award grants to States to carry out initiatives

to provide incentives to Medicaid beneficiaries who—

(i) successfully participate in a program described in paragraph (3); and

(ii) upon completion of such participation, demonstrate changes in health risk and outcomes, including the adoption and maintenance of healthy behaviors by meeting specific targets (as described in subsection (c)(2)).

(B) PURPOSE.—The purpose of the initiatives under this section is to test approaches that may encourage behavior modification and determine scalable solutions.

(2) DURATION.—

(A) INITIATION OF PROGRAM; RESOURCES.—The Secretary shall awards grants to States beginning on January 1, 2011, or beginning on the date on which the Secretary develops program criteria, whichever is earlier. The Secretary shall develop program criteria for initiatives under this section using relevant evidence-based research and resources, including the Guide to Community Preventive Services, the Guide to Clinical Preventive Services, and

1 the National Registry of Evidence-Based Pro-
2 grams and Practices.
3 (B) DURATION OF PROGRAM.—A State
4 awarded a grant to carry out initiatives under
5 this section shall carry out such initiatives with-
6 in the 5-year period beginning on January 1,
7 2011, or beginning on the date on which the
8 Secretary develops program criteria, whichever
9 is earlier. Initiatives under this section shall be
10 carried out by a State for a period of not less
11 than 3 years.
12 (3) PROGRAM DESCRIBED.—
13 (A) IN GENERAL.—A program described in
14 this paragraph is a comprehensive, evidence-
15 based, widely available, and easily accessible
16 program, proposed by the State and approved
17 by the Secretary, that is designed and uniquely
18 suited to address the needs of Medicaid bene-
19 ficiaries and has demonstrated success in help-
20 ing individuals achieve one or more of the fol-
21 lowing:
22 (i) Ceasing use of tobacco products.
23 (ii) Controlling or reducing their
24 weight.
25 (iii) Lowering their cholesterol.

1 (iv) Lowering their blood pressure.
2 (v) Avoiding the onset of diabetes or,
3 in the case of a diabetic, improving the
4 management of that condition.
5 (B) CO-MORBIDITIES.—A program under
6 this section may also address co-morbidities (in-
7 cluding depression) that are related to any of
8 the conditions described in subparagraph (A).
9 (C) WAIVER AUTHORITY.—The Secretary
10 may waive the requirements of section
11 1902(a)(1) (relating to statewideness) of the
12 Social Security Act for a State awarded a grant
13 to conduct an initiative under this section and
14 shall ensure that a State makes any program
15 described in subparagraph (A) available and ac-
16 cessible to Medicaid beneficiaries.
17 (D) FLEXIBILITY IN IMPLEMENTATION.—
18 A State may enter into arrangements with pro-
19 viders participating in Medicaid, community-
20 based organizations, faith-based organizations,
21 public-private partnerships, Indian tribes, or
22 similar entities or organizations to carry out
23 programs described in subparagraph (A).
24 (4) APPLICATION.—Following the development
25 of program criteria by the Secretary, a State may

1 submit an application, in such manner and con-
2 taining such information as the Secretary may re-
3 quire, that shall include a proposal for programs de-
4 scribed in paragraph (3)(A) and a plan to make
5 Medicaid beneficiaries and providers participating in
6 Medicaid who reside in the State aware and in-
7 formed about such programs.
8 (b) EDUCATION AND OUTREACH CAMPAIGN.—
9 (1) STATE AWARENESS.—The Secretary shall
10 conduct an outreach and education campaign to
11 make States aware of the grants under this section.
12 (2) PROVIDER AND BENEFICIARY EDU-
13 CATION.—A State awarded a grant to conduct an
14 initiative under this section shall conduct an out-
15 reach and education campaign to make Medicaid
16 beneficiaries and providers participating in Medicaid
17 who reside in the State aware of the programs de-
18 scribed in subsection (a)(3) that are to be carried
19 out by the State under the grant.
20 (c) IMPACT.—A State awarded a grant to conduct an
21 initiative under this section shall develop and implement
22 a system to—
23 (1) track Medicaid beneficiary participation in
24 the program and validate changes in health risk and
25 outcomes with clinical data, including the adoption

1 and maintenance of health behaviors by such bene-
2 ficiaries;
3 (2) to the extent practicable, establish stand-
4 ards and health status targets for Medicaid bene-
5 ficiaries participating in the program and measure
6 the degree to which such standards and targets are
7 met;
8 (3) evaluate the effectiveness of the program
9 and provide the Secretary with such evaluations;
10 (4) report to the Secretary on processes that
11 have been developed and lessons learned from the
12 program; and
13 (5) report on preventive services as part of re-
14 porting on quality measures for Medicaid managed
15 care programs.
16 (d) EVALUATIONS AND REPORTS.—
17 (1) INDEPENDENT ASSESSMENT.—The Sec-
18 retary shall enter into a contract with an inde-
19 pendent entity or organization to conduct an evalua-
20 tion and assessment of the initiatives carried out by
21 States under this section, for the purpose of deter-
22 mining—
23 (A) the effect of such initiatives on the use
24 of health care services by Medicaid beneficiaries
25 participating in the program;

(B) the extent to which special populations (including adults with disabilities, adults with chronic illnesses, and children with special health care needs) are able to participate in the program;

(C) the level of satisfaction of Medicaid beneficiaries with respect to the accessibility and quality of health care services provided through the program; and

(D) the administrative costs incurred by State agencies that are responsible for administration of the program.

(2) STATE REPORTING.—A State awarded a grant to carry out initiatives under this section shall submit reports to the Secretary, on a semi-annual basis, regarding the programs that are supported by the grant funds. Such report shall include information, as specified by the Secretary, regarding—

(A) the specific uses of the grant funds;

(B) an assessment of program implementation and lessons learned from the programs;

(C) an assessment of quality improvements and clinical outcomes under such programs; and

(D) estimates of cost savings resulting from such programs.

1 (3) INITIAL REPORT.—Not later than January
2 1, 2014, the Secretary shall submit to Congress an
3 initial report on such initiatives based on informa-
4 tion provided by States through reports required
5 under paragraph (2). The initial report shall include
6 an interim evaluation of the effectiveness of the ini-
7 tiatives carried out with grants awarded under this
8 section and a recommendation regarding whether
9 funding for expanding or extending the initiatives
10 should be extended beyond January 1, 2016.
11 (4) FINAL REPORT.—Not later than July 1,
12 2016, the Secretary shall submit to Congress a final
13 report on the program that includes the results of
14 the independent assessment required under para-
15 graph (1), together with recommendations for such
16 legislation and administrative action as the Sec-
17 retary determines appropriate.
18 (e) NO EFFECT ON ELIGIBILITY FOR, OR AMOUNT
19 OF, MEDICAID OR OTHER BENEFITS.—Any incentives
20 provided to a Medicaid beneficiary participating in a pro-
21 gram described in subsection (a)(3) shall not be taken into
22 account for purposes of determining the beneficiary's eligi-
23 bility for, or amount of, benefits under the Medicaid pro-
24 gram or any program funded in whole or in part with Fed-
25 eral funds.

(f) FUNDING.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated for the 5-year period beginning on January 1, 2011, $100,000,000 to the Secretary to carry out this section. Amounts appropriated under this subsection shall remain available until expended.

(g) DEFINITIONS.—In this section:

(1) MEDICAID BENEFICIARY.—The term ''Medicaid beneficiary'' means an individual who is eligible for medical assistance under a State plan or waiver under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) and is enrolled in such plan or waiver.

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

Subtitle C—Creating Healthier Communities

SEC. 4201. COMMUNITY TRANSFORMATION GRANTS.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary''), acting through the Director of the Centers for Disease Control and Prevention (referred to in this section as the ''Director''), shall award competitive grants to State and local governmental agencies and community-

1 based organizations for the implementation, evaluation,
2 and dissemination of evidence-based community preventive
3 health activities in order to reduce chronic disease rates,
4 prevent the development of secondary conditions, address
5 health disparities, and develop a stronger evidence-base of
6 effective prevention programming.

7 (b) ELIGIBILITY.—To be eligible to receive a grant
8 under subsection (a), an entity shall—

9 (1) be—

10 (A) a State governmental agency;

11 (B) a local governmental agency;

12 (C) a national network of community-based
13 organizations;

14 (D) a State or local non-profit organiza-
15 tion; or

16 (E) an Indian tribe; and

17 (2) submit to the Director an application at
18 such time, in such a manner, and containing such
19 information as the Director may require, including a
20 description of the program to be carried out under
21 the grant; and

22 (3) demonstrate a history or capacity, if fund-
23 ed, to develop relationships necessary to engage key
24 stakeholders from multiple sectors within and be-

1 yond health care and across a community, such as
2 healthy futures corps and health care providers.
3 (c) USE OF FUNDS.—
4 (1) IN GENERAL.—An eligible entity shall use
5 amounts received under a grant under this section to
6 carry out programs described in this subsection.
7 (2) COMMUNITY TRANSFORMATION PLAN.—
8 (A) IN GENERAL.—An eligible entity that
9 receives a grant under this section shall submit
10 to the Director (for approval) a detailed plan
11 that includes the policy, environmental, pro-
12 grammatic, and as appropriate infrastructure
13 changes needed to promote healthy living and
14 reduce disparities.
15 (B) ACTIVITIES.—Activities within the
16 plan may focus on (but not be limited to)—
17 (i) creating healthier school environ-
18 ments, including increasing healthy food
19 options, physical activity opportunities,
20 promotion of healthy lifestyle, emotional
21 wellness, and prevention curricula, and ac-
22 tivities to prevent chronic diseases;
23 (ii) creating the infrastructure to sup-
24 port active living and access to nutritious
25 foods in a safe environment;

(iii) developing and promoting programs targeting a variety of age levels to increase access to nutrition, physical activity and smoking cessation, improve social and emotional wellness, enhance safety in a community, or address any other chronic disease priority area identified by the grantee;

(iv) assessing and implementing worksite wellness programming and incentives;

(v) working to highlight healthy options at restaurants and other food venues;

(vi) prioritizing strategies to reduce racial and ethnic disparities, including social, economic, and geographic determinants of health; and

(vii) addressing special populations needs, including all age groups and individuals with disabilities, and individuals in both urban and rural areas.

(3) COMMUNITY-BASED PREVENTION HEALTH ACTIVITIES.—

(A) IN GENERAL.—An eligible entity shall use amounts received under a grant under this section to implement a variety of programs,

1 policies, and infrastructure improvements to
2 promote healthier lifestyles.
3 (B) ACTIVITIES.—An eligible entity shall
4 implement activities detailed in the community
5 transformation plan under paragraph (2).
6 (C) IN-KIND SUPPORT.—An eligible entity
7 may provide in-kind resources such as staff,
8 equipment, or office space in carrying out ac-
9 tivities under this section.
10 (4) EVALUATION.—
11 (A) IN GENERAL.—An eligible entity shall
12 use amounts provided under a grant under this
13 section to conduct activities to measure changes
14 in the prevalence of chronic disease risk factors
15 among community members participating in
16 preventive health activities
17 (B) TYPES OF MEASURES.—In carrying
18 out subparagraph (A), the eligible entity shall,
19 with respect to residents in the community,
20 measure—
21 (i) changes in weight;
22 (ii) changes in proper nutrition;
23 (iii) changes in physical activity;
24 (iv) changes in tobacco use prevalence;

(v) changes in emotional well-being and overall mental health;

(vi) other factors using community-specific data from the Behavioral Risk Factor Surveillance Survey; and

(vii) other factors as determined by the Secretary.

(C) REPORTING.—An eligible entity shall annually submit to the Director a report containing an evaluation of activities carried out under the grant.

(5) DISSEMINATION.—A grantee under this section shall—

(A) meet at least annually in regional or national meetings to discuss challenges, best practices, and lessons learned with respect to activities carried out under the grant; and

(B) develop models for the replication of successful programs and activities and the mentoring of other eligible entities.

(d) TRAINING.—

(1) IN GENERAL.—The Director shall develop a program to provide training for eligible entities on effective strategies for the prevention and control of

1 chronic disease and the link between physical, emo-
2 tional, and social well-being.
3 (2) COMMUNITY TRANSFORMATION PLAN.—The
4 Director shall provide appropriate feedback and
5 technical assistance to grantees to establish commu-
6 nity transformation plans
7 (3) EVALUATION.—The Director shall provide a
8 literature review and framework for the evaluation
9 of programs conducted as part of the grant program
10 under this section, in addition to working with aca-
11 demic institutions or other entities with expertise in
12 outcome evaluation.
13 (e) PROHIBITION.—A grantee shall not use funds
14 provided under a grant under this section to create video
15 games or to carry out any other activities that may lead
16 to higher rates of obesity or inactivity.
17 (f) AUTHORIZATION OF APPROPRIATIONS.—There
18 are authorized to be appropriated to carry out this section,
19 such sums as may be necessary for each fiscal years 2010
20 through 2014.
21 **SEC. 4202. HEALTHY AGING, LIVING WELL; EVALUATION OF**
22 **COMMUNITY-BASED PREVENTION AND**
23 **WELLNESS PROGRAMS FOR MEDICARE BENE-**
24 **FICIARIES.**
25 (a) HEALTHY AGING, LIVING WELL.—

1 (1) IN GENERAL.—The Secretary of Health and
2 Human Services (referred to in this section as the
3 "Secretary"), acting through the Director of the
4 Centers for Disease Control and Prevention, shall
5 award grants to State or local health departments
6 and Indian tribes to carry out 5-year pilot programs
7 to provide public health community interventions,
8 screenings, and where necessary, clinical referrals
9 for individuals who are between 55 and 64 years of
10 age.
11 (2) ELIGIBILITY.—To be eligible to receive a
12 grant under paragraph (1), an entity shall—
13 (A) be—
14 (i) a State health department;
15 (ii) a local health department; or
16 (iii) an Indian tribe;
17 (B) submit to the Secretary an application
18 at such time, in such manner, and containing
19 such information as the Secretary may require
20 including a description of the program to be
21 carried out under the grant;
22 (C) design a strategy for improving the
23 health of the 55-to-64 year-old population
24 through community-based public health inter-
25 ventions; and

(D) demonstrate the capacity, if funded, to develop the relationships necessary with relevant health agencies, health care providers, community-based organizations, and insurers to carry out the activities described in paragraph (3), such relationships to include the identification of a community-based clinical partner, such as a community health center or rural health clinic.

(3) USE OF FUNDS.—

(A) IN GENERAL.—A State or local health department shall use amounts received under a grant under this subsection to carry out a program to provide the services described in this paragraph to individuals who are between 55 and 64 years of age.

(B) PUBLIC HEALTH INTERVENTIONS.—

(i) IN GENERAL.—In developing and implementing such activities, a grantee shall collaborate with the Centers for Disease Control and Prevention and the Administration on Aging, and relevant local agencies and organizations.

(ii) TYPES OF INTERVENTION ACTIVITIES.—Intervention activities conducted

1 under this subparagraph may include ef-
2 forts to improve nutrition, increase phys-
3 ical activity, reduce tobacco use and sub-
4 stance abuse, improve mental health, and
5 promote healthy lifestyles among the target
6 population.
7 (C) COMMUNITY PREVENTIVE
8 SCREENINGS.—
9 (i) IN GENERAL.—In addition to com-
10 munity-wide public health interventions, a
11 State or local health department shall use
12 amounts received under a grant under this
13 subsection to conduct ongoing health
14 screening to identify risk factors for car-
15 diovascular disease, cancer, stroke, and di-
16 abetes among individuals in both urban
17 and rural areas who are between 55 and
18 64 years of age.
19 (ii) TYPES OF SCREENING ACTIVI-
20 TIES.—Screening activities conducted
21 under this subparagraph may include—
22 (I) mental health/behavioral
23 health and substance use disorders;
24 (II) physical activity, smoking,
25 and nutrition; and

1 (III) any other measures deemed
2 appropriate by the Secretary.
3 (iii) MONITORING.—Grantees under
4 this section shall maintain records of
5 screening results under this subparagraph
6 to establish the baseline data for moni-
7 toring the targeted population
8 (D) CLINICAL REFERRAL/TREATMENT FOR
9 CHRONIC DISEASES.—
10 (i) IN GENERAL.—A State or local
11 health department shall use amounts re-
12 ceived under a grant under this subsection
13 to ensure that individuals between 55 and
14 64 years of age who are found to have
15 chronic disease risk factors through the
16 screening activities described in subpara-
17 graph (C)(ii), receive clinical referral/treat-
18 ment for follow-up services to reduce such
19 risk.
20 (ii) MECHANISM.—
21 (I) IDENTIFICATION AND DETER-
22 MINATION OF STATUS.—With respect
23 to each individual with risk factors for
24 or having heart disease, stroke, diabe-
25 tes, or any other condition for which

1 such individual was screened under
2 subparagraph (C), a grantee under
3 this section shall determine whether
4 or not such individual is covered
5 under any public or private health in-
6 surance program.

7 (II) INSURED INDIVIDUALS.—An
8 individual determined to be covered
9 under a health insurance program
10 under subclause (I) shall be referred
11 by the grantee to the existing pro-
12 viders under such program or, if such
13 individual does not have a current
14 provider, to a provider who is in-net-
15 work with respect to the program in-
16 volved.

17 (III) UNINSURED INDIVID-
18 UALS.—With respect to an individual
19 determined to be uninsured under
20 subclause (I), the grantee's commu-
21 nity-based clinical partner described
22 in paragraph (4)(D) shall assist the
23 individual in determining eligibility for
24 available public coverage options and
25 identify other appropriate community

1 health care resources and assistance
2 programs.
3 (iii) PUBLIC HEALTH INTERVENTION
4 PROGRAM.—A State or local health depart-
5 ment shall use amounts received under a
6 grant under this subsection to enter into
7 contracts with community health centers or
8 rural health clinics and mental health and
9 substance use disorder service providers to
10 assist in the referral/treatment of at risk
11 patients to community resources for clin-
12 ical follow-up and help determine eligibility
13 for other public programs.
14 (E) GRANTEE EVALUATION.—An eligible
15 entity shall use amounts provided under a grant
16 under this subsection to conduct activities to
17 measure changes in the prevalence of chronic
18 disease risk factors among participants.
19 (4) PILOT PROGRAM EVALUATION.—The Sec-
20 retary shall conduct an annual evaluation of the ef-
21 fectiveness of the pilot program under this sub-
22 section. In determining such effectiveness, the Sec-
23 retary shall consider changes in the prevalence of
24 uncontrolled chronic disease risk factors among new
25 Medicare enrollees (or individuals nearing enroll-

1 ment, including those who are 63 and 64 years of
2 age) who reside in States or localities receiving
3 grants under this section as compared with national
4 and historical data for those States and localities for
5 the same population.

6 (5) AUTHORIZATION OF APPROPRIATIONS.—
7 There are authorized to be appropriated to carry out
8 this subsection, such sums as may be necessary for
9 each of fiscal years 2010 through 2014.

10 (b) EVALUATION AND PLAN FOR COMMUNITY-BASED
11 PREVENTION AND WELLNESS PROGRAMS FOR MEDICARE
12 BENEFICIARIES.—

13 (1) IN GENERAL.—The Secretary shall conduct
14 an evaluation of community-based prevention and
15 wellness programs and develop a plan for promoting
16 healthy lifestyles and chronic disease self-manage-
17 ment for Medicare beneficiaries.

18 (2) MEDICARE EVALUATION OF PREVENTION
19 AND WELLNESS PROGRAMS.—

20 (A) IN GENERAL.—The Secretary shall
21 evaluate community prevention and wellness
22 programs including those that are sponsored by
23 the Administration on Aging, are evidence-
24 based, and have demonstrated potential to help
25 Medicare beneficiaries (particularly beneficiaries

that have attained 65 years of age) reduce their risk of disease, disability, and injury by making healthy lifestyle choices, including exercise, diet, and self-management of chronic diseases.

(B) EVALUATION.—The evaluation under subparagraph (A) shall consist of the following:

(i) EVIDENCE REVIEW.—The Secretary shall review available evidence, literature, best practices, and resources that are relevant to programs that promote healthy lifestyles and reduce risk factors for the Medicare population. The Secretary may determine the scope of the evidence review and such issues to be considered, which shall include, at a minimum—

(I) physical activity, nutrition, and obesity;

(II) falls;

(III) chronic disease self-management; and

(IV) mental health.

(ii) INDEPENDENT EVALUATION OF EVIDENCE-BASED COMMUNITY PREVENTION AND WELLNESS PROGRAMS.—The Administrator of the Centers for Medicare

& Medicaid Services, in consultation with the Assistant Secretary for Aging, shall, to the extent feasible and practicable, conduct an evaluation of existing community prevention and wellness programs that are sponsored by the Administration on Aging to assess the extent to which Medicare beneficiaries who participate in such programs—

(I) reduce their health risks, improve their health outcomes, and adopt and maintain healthy behaviors;

(II) improve their ability to manage their chronic conditions; and

(III) reduce their utilization of health services and associated costs under the Medicare program for conditions that are amenable to improvement under such programs.

(3) REPORT.—Not later than September 30, 2013, the Secretary shall submit to Congress a report that includes—

(A) recommendations for such legislation and administrative action as the Secretary determines appropriate to promote healthy life-

styles and chronic disease self-management for Medicare beneficiaries;

(B) any relevant findings relating to the evidence review under paragraph (2)(B)(i); and

(C) the results of the evaluation under paragraph (2)(B)(ii).

(4) FUNDING.—For purposes of carrying out this subsection, the Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplemental Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t), in such proportion as the Secretary determines appropriate, of $50,000,000 to the Centers for Medicare & Medicaid Services Program Management Account. Amounts transferred under the preceding sentence shall remain available until expended.

(5) ADMINISTRATION.—Chapter 35 of title 44, United States Code shall not apply to the this subsection.

(6) MEDICARE BENEFICIARY.—In this subsection, the term ''Medicare beneficiary'' means an individual who is entitled to benefits under part A

of title XVIII of the Social Security Act and enrolled under part B of such title.

SEC. 4203. REMOVING BARRIERS AND IMPROVING ACCESS TO WELLNESS FOR INDIVIDUALS WITH DISABILITIES.

Title V of the Rehabilitation Act of 1973 (29 U.S.C. 791 et seq.) is amended by adding at the end of the following:

"SEC. 510. ESTABLISHMENT OF STANDARDS FOR ACCESSIBLE MEDICAL DIAGNOSTIC EQUIPMENT.

''(a) STANDARDS.—Not later than 24 months after the date of enactment of the Affordable Health Choices Act, the Architectural and Transportation Barriers Compliance Board shall, in consultation with the Commissioner of the Food and Drug Administration, promulgate regulatory standards in accordance with the Administrative Procedure Act (2 U.S.C. 551 et seq.) setting forth the minimum technical criteria for medical diagnostic equipment used in (or in conjunction with) physician's offices, clinics, emergency rooms, hospitals, and other medical settings. The standards shall ensure that such equipment is accessible to, and usable by, individuals with accessibility needs, and shall allow independent entry to, use of, and exit from the equipment by such individuals to the maximum extent possible.

1 "(b) MEDICAL DIAGNOSTIC EQUIPMENT COV-
2 ERED.—The standards issued under subsection (a) for
3 medical diagnostic equipment shall apply to equipment
4 that includes examination tables, examination chairs (in-
5 cluding chairs used for eye examinations or procedures,
6 and dental examinations or procedures), weight scales,
7 mammography equipment, x-ray machines, and other radi-
8 ological equipment commonly used for diagnostic purposes
9 by health professionals.

10 "(c) REVIEW AND AMENDMENT.—The Architectural
11 and Transportation Barriers Compliance Board, in con-
12 sultation with the Commissioner of the Food and Drug
13 Administration, shall periodically review and, as appro-
14 priate, amend the standards in accordance with the Ad-
15 ministrative Procedure Act (2 U.S.C. 551 et seq.).".

16 **SEC. 4204. IMMUNIZATIONS.**

17 (a) STATE AUTHORITY TO PURCHASE REC-
18 OMMENDED VACCINES FOR ADULTS.—Section 317 of the
19 Public Health Service Act (42 U.S.C. 247b) is amended
20 by adding at the end the following:

21 "(l) AUTHORITY TO PURCHASE RECOMMENDED VAC-
22 CINES FOR ADULTS.—

23 "(1) IN GENERAL.—The Secretary may nego-
24 tiate and enter into contracts with manufacturers of

1 vaccines for the purchase and delivery of vaccines
2 for adults as provided for under subsection (e).
3 "(2) STATE PURCHASE.—A State may obtain
4 additional quantities of such adult vaccines (subject
5 to amounts specified to the Secretary by the State
6 in advance of negotiations) through the purchase of
7 vaccines from manufacturers at the applicable price
8 negotiated by the Secretary under this subsection.".
9 (b) DEMONSTRATION PROGRAM TO IMPROVE IMMU-
10 NIZATION COVERAGE.—Section 317 of the Public Health
11 Service Act (42 U.S.C. 247b), as amended by subsection
12 (a), is further amended by adding at the end the following:
13 "(m) DEMONSTRATION PROGRAM TO IMPROVE IM-
14 MUNIZATION COVERAGE.—
15 "(1) IN GENERAL.—The Secretary, acting
16 through the Director of the Centers for Disease
17 Control and Prevention, shall establish a demonstra-
18 tion program to award grants to States to improve
19 the provision of recommended immunizations for
20 children, adolescents, and adults through the use of
21 evidence-based, population-based interventions for
22 high-risk populations.
23 "(2) STATE PLAN.—To be eligible for a grant
24 under paragraph (1), a State shall submit to the
25 Secretary an application at such time, in such man-

1 ner, and containing such information as the Sec-
2 retary may require, including a State plan that de-
3 scribes the interventions to be implemented under
4 the grant and how such interventions match with
5 local needs and capabilities, as determined through
6 consultation with local authorities.

7 "(3) USE OF FUNDS.—Funds received under a
8 grant under this subsection shall be used to imple-
9 ment interventions that are recommended by the
10 Task Force on Community Preventive Services (as
11 established by the Secretary, acting through the Di-
12 rector of the Centers for Disease Control and Pre-
13 vention) or other evidence-based interventions, in-
14 cluding—

15 "(A) providing immunization reminders or
16 recalls for target populations of clients, pa-
17 tients, and consumers;

18 "(B) educating targeted populations and
19 health care providers concerning immunizations
20 in combination with one or more other interven-
21 tions;

22 "(C) reducing out-of-pocket costs for fami-
23 lies for vaccines and their administration;

24 "(D) carrying out immunization-promoting
25 strategies for participants or clients of public

1 programs, including assessments of immuniza-
2 tion status, referrals to health care providers,
3 education, provision of on-site immunizations,
4 or incentives for immunization;
5 ''(E) providing for home visits that pro-
6 mote immunization through education, assess-
7 ments of need, referrals, provision of immuniza-
8 tions, or other services;
9 ''(F) providing reminders or recalls for im-
10 munization providers;
11 ''(G) conducting assessments of, and pro-
12 viding feedback to, immunization providers;
13 ''(H) any combination of one or more
14 interventions described in this paragraph; or
15 ''(I) immunization information systems to
16 allow all States to have electronic databases for
17 immunization records.
18 ''(4) CONSIDERATION.—In awarding grants
19 under this subsection, the Secretary shall consider
20 any reviews or recommendations of the Task Force
21 on Community Preventive Services.
22 ''(5) EVALUATION.—Not later than 3 years
23 after the date on which a State receives a grant
24 under this subsection, the State shall submit to the
25 Secretary an evaluation of progress made toward im-

1 proving immunization coverage rates among high-
2 risk populations within the State.
3 "(6) REPORT TO CONGRESS.—Not later than 4
4 years after the date of enactment of the Affordable
5 Health Choices Act, the Secretary shall submit to
6 Congress a report concerning the effectiveness of the
7 demonstration program established under this sub-
8 section together with recommendations on whether
9 to continue and expand such program.
10 "(7) AUTHORIZATION OF APPROPRIATIONS.—
11 There is authorized to be appropriated to carry out
12 this subsection, such sums as may be necessary for
13 each of fiscal years 2010 through 2014.".
14 (c) REAUTHORIZATION OF IMMUNIZATION PRO-
15 GRAM.—Section 317(j) of the Public Health Service Act
16 (42 U.S.C. 247b(j)) is amended—
17 (1) in paragraph (1), by striking "for each of
18 the fiscal years 1998 through 2005"; and
19 (2) in paragraph (2), by striking "after October
20 1, 1997,".
21 (d) RULE OF CONSTRUCTION REGARDING ACCESS TO
22 IMMUNIZATIONS.—Nothing in this section (including the
23 amendments made by this section), or any other provision
24 of this Act (including any amendments made by this Act)

1 shall be construed to decrease children's access to immuni-
2 zations.

3 (e) GAO STUDY AND REPORT ON MEDICARE BENE-
4 FICIARY ACCESS TO VACCINES.—

5 (1) STUDY.—The Comptroller General of the
6 United States (in this section referred to as the
7 "Comptroller General") shall conduct a study on the
8 ability of Medicare beneficiaries who were 65 years
9 of age or older to access routinely recommended vac-
10 cines covered under the prescription drug program
11 under part D of title XVIII of the Social Security
12 Act over the period since the establishment of such
13 program. Such study shall include the following:

14 (A) An analysis and determination of—

15 (i) the number of Medicare bene-
16 ficiaries who were 65 years of age or older
17 and were eligible for a routinely rec-
18 ommended vaccination that was covered
19 under part D;

20 (ii) the number of such beneficiaries
21 who actually received a routinely rec-
22 ommended vaccination that was covered
23 under part D; and

24 (iii) any barriers to access by such
25 beneficiaries to routinely recommended

1 vaccinations that were covered under part
2 D.
3 (B) A summary of the findings and rec-
4 ommendations by government agencies, depart-
5 ments, and advisory bodies (as well as relevant
6 professional organizations) on the impact of
7 coverage under part D of routinely rec-
8 ommended adult immunizations for access to
9 such immunizations by Medicare beneficiaries.
10 (2) REPORT.—Not later than June 1, 2011, the
11 Comptroller General shall submit to the appropriate
12 committees of jurisdiction of the House of Rep-
13 resentatives and the Senate a report containing the
14 results of the study conducted under paragraph (1),
15 together with recommendations for such legislation
16 and administrative action as the Comptroller Gen-
17 eral determines appropriate.
18 (3) FUNDING.—Out of any funds in the Treas-
19 ury not otherwise appropriated, there are appro-
20 priated $1,000,000 for fiscal year 2010 to carry out
21 this subsection.

SEC. 4205. NUTRITION LABELING OF STANDARD MENU ITEMS AT CHAIN RESTAURANTS.

(a) TECHNICAL AMENDMENTS.—Section 403(q)(5)(A) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 343(q)(5)(A)) is amended—

(1) in subitem (i), by inserting at the beginning ''except as provided in clause (H)(ii)(III),''; and

(2) in subitem (ii), by inserting at the beginning ''except as provided in clause (H)(ii)(III),''.

(b) LABELING REQUIREMENTS.—Section 403(q)(5) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 343(q)(5)) is amended by adding at the end the following:

''(H) RESTAURANTS, RETAIL FOOD ESTABLISHMENTS, AND VENDING MACHINES.—

''(i) GENERAL REQUIREMENTS FOR RESTAURANTS AND SIMILAR RETAIL FOOD ESTABLISHMENTS.—Except for food described in subclause (vii), in the case of food that is a standard menu item that is offered for sale in a restaurant or similar retail food establishment that is part of a chain with 20 or more locations doing business under the same name (regardless of the type of ownership of the locations) and offering for sale substantially the same menu items, the restaurant or similar retail food establishment shall disclose the information described in subclauses (ii) and (iii).

"(ii) INFORMATION REQUIRED TO BE DISCLOSED BY RESTAURANTS AND RETAIL FOOD ESTABLISHMENTS.—Except as provided in subclause (vii), the restaurant or similar retail food establishment shall disclose in a clear and conspicuous manner—

"(I)(aa) in a nutrient content disclosure statement adjacent to the name of the standard menu item, so as to be clearly associated with the standard menu item, on the menu listing the item for sale, the number of calories contained in the standard menu item, as usually prepared and offered for sale; and

"(bb) a succinct statement concerning suggested daily caloric intake, as specified by the Secretary by regulation and posted prominently on the menu and designed to enable the public to understand, in the context of a total daily diet, the significance of the caloric information that is provided on the menu;

"(II)(aa) in a nutrient content disclosure statement adjacent to the name of the standard menu item, so as to be clearly associated with the standard menu item, on the menu board, including a drive-through menu board, the

number of calories contained in the standard menu item, as usually prepared and offered for sale; and

"(bb) a succinct statement concerning suggested daily caloric intake, as specified by the Secretary by regulation and posted prominently on the menu board, designed to enable the public to understand, in the context of a total daily diet, the significance of the nutrition information that is provided on the menu board;

"(III) in a written form, available on the premises of the restaurant or similar retail establishment and to the consumer upon request, the nutrition information required under clauses (C) and (D) of subparagraph (1); and

"(IV) on the menu or menu board, a prominent, clear, and conspicuous statement regarding the availability of the information described in item (III).

"(iii) SELF-SERVICE FOOD AND FOOD ON DISPLAY.—Except as provided in subclause (vii), in the case of food sold at a salad bar, buffet line, cafeteria line, or similar self-service facility, and for self-service beverages or food that is on display and that is visible to customers, a restaurant or similar retail

1 food establishment shall place adjacent to each food
2 offered a sign that lists calories per displayed food
3 item or per serving.

4 ''(iv) REASONABLE BASIS.—For the purposes of
5 this clause, a restaurant or similar retail food estab-
6 lishment shall have a reasonable basis for its nutri-
7 ent content disclosures, including nutrient databases,
8 cookbooks, laboratory analyses, and other reasonable
9 means, as described in section 101.10 of title 21,
10 Code of Federal Regulations (or any successor regu-
11 lation) or in a related guidance of the Food and
12 Drug Administration.

13 ''(v) MENU VARIABILITY AND COMBINATION
14 MEALS.—The Secretary shall establish by regulation
15 standards for determining and disclosing the nutri-
16 ent content for standard menu items that come in
17 different flavors, varieties, or combinations, but
18 which are listed as a single menu item, such as soft
19 drinks, ice cream, pizza, doughnuts, or children's
20 combination meals, through means determined by
21 the Secretary, including ranges, averages, or other
22 methods.

23 ''(vi) ADDITIONAL INFORMATION.—If the Sec-
24 retary determines that a nutrient, other than a nu-
25 trient required under subclause (ii)(III), should be

disclosed for the purpose of providing information to assist consumers in maintaining healthy dietary practices, the Secretary may require, by regulation, disclosure of such nutrient in the written form required under subclause (ii)(III).

"(vii) NONAPPLICABILITY TO CERTAIN FOOD.—

"(I) IN GENERAL.—Subclauses (i) through (vi) do not apply to—

"(aa) items that are not listed on a menu or menu board (such as condiments and other items placed on the table or counter for general use);

"(bb) daily specials, temporary menu items appearing on the menu for less than 60 days per calendar year, or custom orders; or

"(cc) such other food that is part of a customary market test appearing on the menu for less than 90 days, under terms and conditions established by the Secretary.

"(II) WRITTEN FORMS.—Subparagraph (5)(C) shall apply to any regulations promulgated under subclauses (ii)(III) and (vi).

"(viii) VENDING MACHINES.—

"(I) IN GENERAL.—In the case of an article of food sold from a vending machine that—

"(aa) does not permit a prospective purchaser to examine the Nutrition Facts Panel before purchasing the article or does not otherwise provide visible nutrition information at the point of purchase; and

"(bb) is operated by a person who is engaged in the business of owning or operating 20 or more vending machines,

the vending machine operator shall provide a sign in close proximity to each article of food or the selection button that includes a clear and conspicuous statement disclosing the number of calories contained in the article.

"(ix) VOLUNTARY PROVISION OF NUTRITION INFORMATION.—

"(I) IN GENERAL.—An authorized official of any restaurant or similar retail food establishment or vending machine operator not subject to the requirements of this clause may elect to be subject to the requirements of such clause, by registering biannually the name and address of such restaurant or similar retail food establishment or vending machine operator with

the Secretary, as specified by the Secretary by regulation.

"(II) REGISTRATION.—Within 120 days of enactment of this clause, the Secretary shall publish a notice in the Federal Register specifying the terms and conditions for implementation of item (I), pending promulgation of regulations.

"(III) RULE OF CONSTRUCTION.—Nothing in this subclause shall be construed to authorize the Secretary to require an application, review, or licensing process for any entity to register with the Secretary, as described in such item.

"(x) REGULATIONS.—

"(I) PROPOSED REGULATION.—Not later than 1 year after the date of enactment of this clause, the Secretary shall promulgate proposed regulations to carry out this clause.

"(II) CONTENTS.—In promulgating regulations, the Secretary shall—

"(aa) consider standardization of recipes and methods of preparation, reasonable variation in serving size and formulation of menu items, space on menus and menu boards, inadvertent human error,

training of food service workers, variations in ingredients, and other factors, as the Secretary determines; and

"(bb) specify the format and manner of the nutrient content disclosure requirements under this subclause.

"(III) REPORTING.—The Secretary shall submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a quarterly report that describes the Secretary's progress toward promulgating final regulations under this subparagraph.

"(xi) DEFINITION.—In this clause, the term 'menu' or 'menu board' means the primary writing of the restaurant or other similar retail food establishment from which a consumer makes an order selection."

(c) NATIONAL UNIFORMITY.—Section 403A(a)(4) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 343-1(a)(4)) is amended by striking "except a requirement for nutrition labeling of food which is exempt under subclause (i) or (ii) of section 403(q)(5)(A)" and inserting "except that this paragraph does not apply to food that

is offered for sale in a restaurant or similar retail food establishment that is not part of a chain with 20 or more locations doing business under the same name (regardless of the type of ownership of the locations) and offering for sale substantially the same menu items unless such restaurant or similar retail food establishment complies with the voluntary provision of nutrition information requirements under section 403(q)(5)(H)(ix)''.

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

(1) to preempt any provision of State or local law, unless such provision establishes or continues into effect nutrient content disclosures of the type required under section 403(q)(5)(H) of the Federal Food, Drug, and Cosmetic Act (as added by subsection (b)) and is expressly preempted under subsection (a)(4) of such section;

(2) to apply to any State or local requirement respecting a statement in the labeling of food that provides for a warning concerning the safety of the food or component of the food; or

(3) except as provided in section 403(q)(5)(H)(ix) of the Federal Food, Drug, and Cosmetic Act (as added by subsection (b)), to apply to any restaurant or similar retail food establish-

ment other than a restaurant or similar retail food establishment described in section 403(q)(5)(H)(i) of such Act.

SEC. 4206. DEMONSTRATION PROJECT CONCERNING INDIVIDUALIZED WELLNESS PLAN.

Section 330 of the Public Health Service Act (42 U.S.C. 245b) is amended by adding at the end the following:

''(s) DEMONSTRATION PROGRAM FOR INDIVIDUALIZED WELLNESS PLANS.—

''(1) IN GENERAL.—The Secretary shall establish a pilot program to test the impact of providing at-risk populations who utilize community health centers funded under this section an individualized wellness plan that is designed to reduce risk factors for preventable conditions as identified by a comprehensive risk-factor assessment.

''(2) AGREEMENTS.—The Secretary shall enter into agreements with not more than 10 community health centers funded under this section to conduct activities under the pilot program under paragraph (1).

''(3) WELLNESS PLANS.—

''(A) IN GENERAL.—An individualized wellness plan prepared under the pilot program

1 under this subsection may include one or more
2 of the following as appropriate to the individ-
3 ual's identified risk factors:
4 "(i) Nutritional counseling.
5 "(ii) A physical activity plan.
6 "(iii) Alcohol and smoking cessation
7 counseling and services.
8 "(iv) Stress management.
9 "(v) Dietary supplements that have
10 health claims approved by the Secretary.
11 "(vi) Compliance assistance provided
12 by a community health center employee.
13 "(B) RISK FACTORS.—Wellness plan risk
14 factors shall include—
15 "(i) weight;
16 "(ii) tobacco and alcohol use;
17 "(iii) exercise rates;
18 "(iv) nutritional status; and
19 "(v) blood pressure.
20 "(C) COMPARISONS.—Individualized
21 wellness plans shall make comparisons between
22 the individual involved and a control group of
23 individuals with respect to the risk factors de-
24 scribed in subparagraph (B).

"(4) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this subsection, such sums as may be necessary.".

SEC. 4207. REASONABLE BREAK TIME FOR NURSING MOTHERS.

Section 7 of the Fair Labor Standards Act of 1938 (29 U.S.C. 207) is amended by adding at the end the following:

"(r)(1) An employer shall provide—

"(A) a reasonable break time for an employee to express breast milk for her nursing child for 1 year after the child's birth each time such employee has need to express the milk; and

"(B) a place, other than a bathroom, that is shielded from view and free from intrusion from co-workers and the public, which may be used by an employee to express breast milk.

"(2) An employer shall not be required to compensate an employee receiving reasonable break time under paragraph (1) for any work time spent for such purpose.

"(3) An employer that employs less than 50 employees shall not be subject to the requirements of this subsection, if such requirements would impose an undue hardship by causing the employer significant difficulty or ex-

pense when considered in relation to the size, financial resources, nature, or structure of the employer's business.

"(4) Nothing in this subsection shall preempt a State law that provides greater protections to employees than the protections provided for under this subsection.".

Subtitle D—Support for Prevention and Public Health Innovation

SEC. 4301. RESEARCH ON OPTIMIZING THE DELIVERY OF PUBLIC HEALTH SERVICES.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the "Secretary"), acting through the Director of the Centers for Disease Control and Prevention, shall provide funding for research in the area of public health services and systems.

(b) REQUIREMENTS OF RESEARCH.—Research supported under this section shall include—

(1) examining evidence-based practices relating to prevention, with a particular focus on high priority areas as identified by the Secretary in the National Prevention Strategy or Healthy People 2020, and including comparing community-based public health interventions in terms of effectiveness and cost;

(2) analyzing the translation of interventions from academic settings to real world settings; and

(3) identifying effective strategies for organizing, financing, or delivering public health services in real world community settings, including comparing State and local health department structures and systems in terms of effectiveness and cost.

(c) EXISTING PARTNERSHIPS.—Research supported under this section shall be coordinated with the Community Preventive Services Task Force and carried out by building on existing partnerships within the Federal Government while also considering initiatives at the State and local levels and in the private sector.

(d) ANNUAL REPORT.—The Secretary shall, on an annual basis, submit to Congress a report concerning the activities and findings with respect to research supported under this section.

SEC. 4302. UNDERSTANDING HEALTH DISPARITIES: DATA COLLECTION AND ANALYSIS.

(a) UNIFORM CATEGORIES AND COLLECTION REQUIREMENTS.—The Public Health Service Act (42 U.S.C. 201 et seq.) is amended by adding at the end the following:

"TITLE XXXI—DATA COLLECTION, ANALYSIS, AND QUALITY

"SEC. 3101. DATA COLLECTION, ANALYSIS, AND QUALITY.

''(a) DATA COLLECTION.—

''(1) IN GENERAL.—The Secretary shall ensure that, by not later than 2 years after the date of enactment of this title, any federally conducted or supported health care or public health program, activity or survey (including Current Population Surveys and American Community Surveys conducted by the Bureau of Labor Statistics and the Bureau of the Census) collects and reports, to the extent practicable—

''(A) data on race, ethnicity, sex, primary language, and disability status for applicants, recipients, or participants;

''(B) data at the smallest geographic level such as State, local, or institutional levels if such data can be aggregated;

''(C) sufficient data to generate statistically reliable estimates by racial, ethnic, sex, primary language, and disability status subgroups for applicants, recipients or participants using, if needed, statistical oversamples of these subpopulations; and

1 "(D) any other demographic data as
2 deemed appropriate by the Secretary regarding
3 health disparities.
4 "(2) COLLECTION STANDARDS.—In collecting
5 data described in paragraph (1), the Secretary or
6 designee shall—
7 "(A) use Office of Management and Budg-
8 et standards, at a minimum, for race and eth-
9 nicity measures;
10 "(B) develop standards for the measure-
11 ment of sex, primary language, and disability
12 status;
13 "(C) develop standards for the collection of
14 data described in paragraph (1) that, at a min-
15 imum—
16 "(i) collects self-reported data by the
17 applicant, recipient, or participant; and
18 "(ii) collects data from a parent or
19 legal guardian if the applicant, recipient,
20 or participant is a minor or legally inca-
21 pacitated;
22 "(D) survey health care providers and es-
23 tablish other procedures in order to assess ac-
24 cess to care and treatment for individuals with
25 disabilities and to identify—

1 "(i) locations where individuals with
2 disabilities access primary, acute (including
3 intensive), and long-term care;
4 "(ii) the number of providers with ac-
5 cessible facilities and equipment to meet
6 the needs of the individuals with disabil-
7 ities, including medical diagnostic equip-
8 ment that meets the minimum technical
9 criteria set forth in section 510 of the Re-
10 habilitation Act of 1973; and
11 "(iii) the number of employees of
12 health care providers trained in disability
13 awareness and patient care of individuals
14 with disabilities; and
15 "(E) require that any reporting require-
16 ment imposed for purposes of measuring quality
17 under any ongoing or federally conducted or
18 supported health care or public health program,
19 activity, or survey includes requirements for the
20 collection of data on individuals receiving health
21 care items or services under such programs ac-
22 tivities by race, ethnicity, sex, primary lan-
23 guage, and disability status.
24 "(3) DATA MANAGEMENT.—In collecting data
25 described in paragraph (1), the Secretary, acting

through the National Coordinator for Health Information Technology shall—

"(A) develop national standards for the management of data collected; and

"(B) develop interoperability and security systems for data management.

"(b) DATA ANALYSIS.—

"(1) IN GENERAL.—For each federally conducted or supported health care or public health program or activity, the Secretary shall analyze data collected under paragraph (a) to detect and monitor trends in health disparities (as defined for purposes of section 485E) at the Federal and State levels.

"(c) DATA REPORTING AND DISSEMINATION.—

"(1) IN GENERAL.—The Secretary shall make the analyses described in (b) available to—

"(A) the Office of Minority Health;

"(B) the National Center on Minority Health and Health Disparities;

"(C) the Agency for Healthcare Research and Quality;

"(D) the Centers for Disease Control and Prevention;

"(E) the Centers for Medicare & Medicaid Services;

1 "(F) the Indian Health Service and epide-
2 miology centers funded under the Indian Health
3 Care Improvement Act;
4 "(G) the Office of Rural health;
5 "(H) other agencies within the Department
6 of Health and Human Services; and
7 "(I) other entities as determined appro-
8 priate by the Secretary.
9 "(2) REPORTING OF DATA.—The Secretary
10 shall report data and analyses described in (a) and
11 (b) through—
12 "(A) public postings on the Internet
13 websites of the Department of Health and
14 Human Services; and
15 "(B) any other reporting or dissemination
16 mechanisms determined appropriate by the Sec-
17 retary.
18 "(3) AVAILABILITY OF DATA.—The Secretary
19 may make data described in (a) and (b) available for
20 additional research, analyses, and dissemination to
21 other Federal agencies, non-governmental entities,
22 and the public, in accordance with any Federal agen-
23 cy's data user agreements.
24 "(d) LIMITATIONS ON USE OF DATA.—Nothing in
25 this section shall be construed to permit the use of infor-

1 mation collected under this section in a manner that would
2 adversely affect any individual.
3 "(e) PROTECTION AND SHARING OF DATA.—
4 "(1) PRIVACY AND OTHER SAFEGUARDS.—The
5 Secretary shall ensure (through the promulgation of
6 regulations or otherwise) that—
7 "(A) all data collected pursuant to sub-
8 section (a) is protected—
9 "(i) under privacy protections that are
10 at least as broad as those that the Sec-
11 retary applies to other health data under
12 the regulations promulgated under section
13 264(c) of the Health Insurance Portability
14 and Accountability Act of 1996 (Public
15 Law 104-191; 110 Stat. 2033); and
16 "(ii) from all inappropriate internal
17 use by any entity that collects, stores, or
18 receives the data, including use of such
19 data in determinations of eligibility (or
20 continued eligibility) in health plans, and
21 from other inappropriate uses, as defined
22 by the Secretary; and
23 "(B) all appropriate information security
24 safeguards are used in the collection, analysis,

and sharing of data collected pursuant to subsection (a).

"(2) DATA SHARING.—The Secretary shall establish procedures for sharing data collected pursuant to subsection (a), measures relating to such data, and analyses of such data, with other relevant Federal and State agencies including the agencies, centers, and entities within the Department of Health and Human Services specified in subsection (c)(1)..

"(f) DATA ON RURAL UNDERSERVED POPULATIONS.—The Secretary shall ensure that any data collected in accordance with this section regarding racial and ethnic minority groups are also collected regarding underserved rural and frontier populations.

"(g) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2010 through 2014.

"(h) REQUIREMENT FOR IMPLEMENTATION.—Notwithstanding any other provision of this section, data may not be collected under this section unless funds are directly appropriated for such purpose in an appropriations Act.

"(i) CONSULTATION.—The Secretary shall consult with the Director of the Office of Personnel Management, the Secretary of Defense, the Secretary of Veterans Affairs, the Director of the Bureau of the Census, the Commissioner of Social Security, and the head of other appropriate Federal agencies in carrying out this section.".

(b) ADDRESSING HEALTH CARE DISPARITIES IN MEDICAID AND CHIP.—

(1) STANDARDIZED COLLECTION REQUIREMENTS INCLUDED IN STATE PLANS.—

(A) MEDICAID.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by section 2001(d), is amended—

(i) in paragraph 4), by striking "and" at the end;

(ii) in paragraph (75), by striking the period at the end and inserting "; and"; and

(iii) by inserting after paragraph (75) the following new paragraph:

"(76) provide that any data collected under the State plan meets the requirements of section 3101 of the Public Health Service Act.".

(B) CHIP.—Section 2108(e) of the Social Security Act (42 U.S.C. 1397hh(e)) is amended

by adding at the end the following new paragraph:

''(7) Data collected and reported in accordance with section 3101 of the Public Health Service Act, with respect to individuals enrolled in the State child health plan (and, in the case of enrollees under 19 years of age, their parents or legal guardians), including data regarding the primary language of such individuals, parents, and legal guardians.''.

(2) EXTENDING MEDICARE REQUIREMENT TO ADDRESS HEALTH DISPARITIES DATA COLLECTION TO MEDICAID AND CHIP.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), as amended by section 2703 is amended by adding at the end the following new section:

''SEC. 1946. ADDRESSING HEALTH CARE DISPARITIES.

''(a) EVALUATING DATA COLLECTION APPROACHES.—The Secretary shall evaluate approaches for the collection of data under this title and title XXI, to be performed in conjunction with existing quality reporting requirements and programs under this title and title XXI, that allow for the ongoing, accurate, and timely collection and evaluation of data on disparities in health care services and performance on the basis of race, ethnicity, sex, primary language, and disability status. In conducting

1 such evaluation, the Secretary shall consider the following
2 objectives:
3 "(1) Protecting patient privacy.
4 "(2) Minimizing the administrative burdens of
5 data collection and reporting on States, providers,
6 and health plans participating under this title or
7 title XXI.
8 "(3) Improving program data under this title
9 and title XXI on race, ethnicity, sex, primary lan-
10 guage, and disability status.
11 "(b) REPORTS TO CONGRESS.—
12 "(1) REPORT ON EVALUATION.—Not later than
13 18 months after the date of the enactment of this
14 section, the Secretary shall submit to Congress a re-
15 port on the evaluation conducted under subsection
16 (a). Such report shall, taking into consideration the
17 results of such evaluation—
18 "(A) identify approaches (including defin-
19 ing methodologies) for identifying and collecting
20 and evaluating data on health care disparities
21 on the basis of race, ethnicity, sex, primary lan-
22 guage, and disability status for the programs
23 under this title and title XXI; and
24 "(B) include recommendations on the most
25 effective strategies and approaches to reporting

HEDIS quality measures as required under section 1852(e)(3) and other nationally recognized quality performance measures, as appropriate, on such bases.

"(2) REPORTS ON DATA ANALYSES.—Not later than 4 years after the date of the enactment of this section, and 4 years thereafter, the Secretary shall submit to Congress a report that includes recommendations for improving the identification of health care disparities for beneficiaries under this title and under title XXI based on analyses of the data collected under subsection (c).

"(c) IMPLEMENTING EFFECTIVE APPROACHES.—Not later than 24 months after the date of the enactment of this section, the Secretary shall implement the approaches identified in the report submitted under subsection (b)(1) for the ongoing, accurate, and timely collection and evaluation of data on health care disparities on the basis of race, ethnicity, sex, primary language, and disability status.".

SEC. 4303. CDC AND EMPLOYER-BASED WELLNESS PROGRAMS.

Title III of the Public Health Service Act (42 U.S.C. 241 et seq.), by section 4102, is further amended by adding at the end the following:

1 **"PART U—EMPLOYER-BASED WELLNESS**
2 **PROGRAM**

3 **"SEC. 399MM. TECHNICAL ASSISTANCE FOR EMPLOYER-**
4 **BASED WELLNESS PROGRAMS.**

5 ''In order to expand the utilization of evidence-based
6 prevention and health promotion approaches in the work-
7 place, the Director shall—

8 ''(1) provide employers (including small, me-
9 dium, and large employers, as determined by the Di-
10 rector) with technical assistance, consultation, tools,
11 and other resources in evaluating such employers'
12 employer-based wellness programs, including—

13 ''(A) measuring the participation and
14 methods to increase participation of employees
15 in such programs;

16 ''(B) developing standardized measures
17 that assess policy, environmental and systems
18 changes necessary to have a positive health im-
19 pact on employees' health behaviors, health out-
20 comes, and health care expenditures; and

21 ''(C) evaluating such programs as they re-
22 late to changes in the health status of employ-
23 ees, the absenteeism of employees, the produc-
24 tivity of employees, the rate of workplace in-
25 jury, and the medical costs incurred by employ-
26 ees; and

"(2) build evaluation capacity among workplace staff by training employers on how to evaluate employer-based wellness programs by ensuring evaluation resources, technical assistance, and consultation are available to workplace staff as needed through such mechanisms as web portals, call centers, or other means.

"SEC. 399MM-1. NATIONAL WORKSITE HEALTH POLICIES AND PROGRAMS STUDY.

"(a) IN GENERAL.—In order to assess, analyze, and monitor over time data about workplace policies and programs, and to develop instruments to assess and evaluate comprehensive workplace chronic disease prevention and health promotion programs, policies and practices, not later than 2 years after the date of enactment of this part, and at regular intervals (to be determined by the Director) thereafter, the Director shall conduct a national worksite health policies and programs survey to assess employer-based health policies and programs.

"(b) REPORT.—Upon the completion of each study under subsection (a), the Director shall submit to Congress a report that includes the recommendations of the Director for the implementation of effective employer-based health policies and programs.

"SEC. 399MM–2. PRIORITIZATION OF EVALUATION BY SECRETARY.

''The Secretary shall evaluate, in accordance with this part, all programs funded through the Centers for Disease Control and Prevention before conducting such an evaluation of privately funded programs unless an entity with a privately funded wellness program requests such an evaluation.

"SEC. 399MM–3. PROHIBITION OF FEDERAL WORKPLACE WELLNESS REQUIREMENTS.

''Notwithstanding any other provision of this part, any recommendations, data, or assessments carried out under this part shall not be used to mandate requirements for workplace wellness programs.''.

SEC. 4304. EPIDEMIOLOGY-LABORATORY CAPACITY GRANTS.

Title XXVIII of the Public Health Service Act (42 U.S.C. 300hh et seq.) is amended by adding at the end the following:

"Subtitle C—Strengthening Public Health Surveillance Systems

"SEC. 2821. EPIDEMIOLOGY-LABORATORY CAPACITY GRANTS.

''(a) IN GENERAL.—Subject to the availability of appropriations, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall

establish an Epidemiology and Laboratory Capacity Grant Program to award grants to State health departments as well as local health departments and tribal jurisdictions that meet such criteria as the Director determines appropriate. Academic centers that assist State and eligible local and tribal health departments may also be eligible for funding under this section as the Director determines appropriate. Grants shall be awarded under this section to assist public health agencies in improving surveillance for, and response to, infectious diseases and other conditions of public health importance by—

"(1) strengthening epidemiologic capacity to identify and monitor the occurrence of infectious diseases and other conditions of public health importance;

"(2) enhancing laboratory practice as well as systems to report test orders and results electronically;

"(3) improving information systems including developing and maintaining an information exchange using national guidelines and complying with capacities and functions determined by an advisory council established and appointed by the Director; and

"(4) developing and implementing prevention and control strategies.

"(b) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $190,000,000 for each of fiscal years 2010 through 2013, of which—

"(1) not less than $95,000,000 shall be made available each such fiscal year for activities under paragraphs (1) and (4) of subsection (a);

"(2) not less than $60,000,000 shall be made available each such fiscal year for activities under subsection (a)(3); and

"(3) not less than $32,000,000 shall be made available each such fiscal year for activities under subsection (a)(2).".

SEC. 4305. ADVANCING RESEARCH AND TREATMENT FOR PAIN CARE MANAGEMENT.

(a) INSTITUTE OF MEDICINE CONFERENCE ON PAIN.—

(1) CONVENING.—Not later than 1 year after funds are appropriated to carry out this subsection, the Secretary of Health and Human Services shall seek to enter into an agreement with the Institute of Medicine of the National Academies to convene a Conference on Pain (in this subsection referred to as "the Conference").

1 (2) PURPOSES.—The purposes of the Con-
2 ference shall be to—
3 (A) increase the recognition of pain as a
4 significant public health problem in the United
5 States;
6 (B) evaluate the adequacy of assessment,
7 diagnosis, treatment, and management of acute
8 and chronic pain in the general population, and
9 in identified racial, ethnic, gender, age, and
10 other demographic groups that may be dis-
11 proportionately affected by inadequacies in the
12 assessment, diagnosis, treatment, and manage-
13 ment of pain;
14 (C) identify barriers to appropriate pain
15 care;
16 (D) establish an agenda for action in both
17 the public and private sectors that will reduce
18 such barriers and significantly improve the
19 state of pain care research, education, and clin-
20 ical care in the United States.
21 (3) OTHER APPROPRIATE ENTITY.—If the In-
22 stitute of Medicine declines to enter into an agree-
23 ment under paragraph (1), the Secretary of Health
24 and Human Services may enter into such agreement
25 with another appropriate entity.

(4) REPORT.—A report summarizing the Conference's findings and recommendations shall be submitted to the Congress not later than June 30, 2011.

(5) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this subsection, there is authorized to be appropriated such sums as may be necessary for each of fiscal years 2010 and 2011.

(b) PAIN RESEARCH AT NATIONAL INSTITUTES OF HEALTH.—Part B of title IV of the Public Health Service Act (42 U.S.C. 284 et seq.) is amended by adding at the end the following:

"SEC. 409J. PAIN RESEARCH.

''(a) RESEARCH INITIATIVES.—

''(1) IN GENERAL.—The Director of NIH is encouraged to continue and expand, through the Pain Consortium, an aggressive program of basic and clinical research on the causes of and potential treatments for pain.

''(2) ANNUAL RECOMMENDATIONS.—Not less than annually, the Pain Consortium, in consultation with the Division of Program Coordination, Planning, and Strategic Initiatives, shall develop and submit to the Director of NIH recommendations on appropriate pain research initiatives that could be

1 undertaken with funds reserved under section
2 402A(c)(1) for the Common Fund or otherwise
3 available for such initiatives.
4 "(3) DEFINITION.—In this subsection, the term
5 'Pain Consortium' means the Pain Consortium of
6 the National Institutes of Health or a similar trans-
7 National Institutes of Health coordinating entity
8 designated by the Secretary for purposes of this sub-
9 section.
10 "(b) INTERAGENCY PAIN RESEARCH COORDINATING
11 COMMITTEE.—
12 "(1) ESTABLISHMENT.—The Secretary shall es-
13 tablish not later than 1 year after the date of the
14 enactment of this section and as necessary maintain
15 a committee, to be known as the Interagency Pain
16 Research Coordinating Committee (in this section
17 referred to as the 'Committee'), to coordinate all ef-
18 forts within the Department of Health and Human
19 Services and other Federal agencies that relate to
20 pain research.
21 "(2) MEMBERSHIP.—
22 "(A) IN GENERAL.—The Committee shall
23 be composed of the following voting members:
24 "(i) Not more than 7 voting Federal
25 representatives appoint by the Secretary

from agencies that conduct pain care research and treatment.

"(ii) 12 additional voting members appointed under subparagraph (B).

"(B) ADDITIONAL MEMBERS.—The Committee shall include additional voting members appointed by the Secretary as follows:

"(i) 6 non-Federal members shall be appointed from among scientists, physicians, and other health professionals.

"(ii) 6 members shall be appointed from members of the general public, who are representatives of leading research, advocacy, and service organizations for individuals with pain-related conditions.

"(C) NONVOTING MEMBERS.—The Committee shall include such nonvoting members as the Secretary determines to be appropriate.

"(3) CHAIRPERSON.—The voting members of the Committee shall select a chairperson from among such members. The selection of a chairperson shall be subject to the approval of the Director of NIH.

"(4) MEETINGS.—The Committee shall meet at the call of the chairperson of the Committee or upon

the request of the Director of NIH, but in no case less often than once each year.

"(5) DUTIES.—The Committee shall—

"(A) develop a summary of advances in pain care research supported or conducted by the Federal agencies relevant to the diagnosis, prevention, and treatment of pain and diseases and disorders associated with pain;

"(B) identify critical gaps in basic and clinical research on the symptoms and causes of pain;

"(C) make recommendations to ensure that the activities of the National Institutes of Health and other Federal agencies are free of unnecessary duplication of effort;

"(D) make recommendations on how best to disseminate information on pain care; and

"(E) make recommendations on how to expand partnerships between public entities and private entities to expand collaborative, cross-cutting research.

"(6) REVIEW.—The Secretary shall review the necessity of the Committee at least once every 2 years.".

1 (c) PAIN CARE EDUCATION AND TRAINING.—Part D
2 of title VII of the Public Health Service Act (42 U.S.C.
3 294 et seq.) is amended by adding at the end the following
4 new section:

5 **"SEC. 759. PROGRAM FOR EDUCATION AND TRAINING IN**
6 **PAIN CARE.**

7 "(a) IN GENERAL.—The Secretary may make awards
8 of grants, cooperative agreements, and contracts to health
9 professions schools, hospices, and other public and private
10 entities for the development and implementation of pro-
11 grams to provide education and training to health care
12 professionals in pain care.

13 "(b) CERTAIN TOPICS.—An award may be made
14 under subsection (a) only if the applicant for the award
15 agrees that the program carried out with the award will
16 include information and education on—

17 "(1) recognized means for assessing, diag-
18 nosing, treating, and managing pain and related
19 signs and symptoms, including the medically appro-
20 priate use of controlled substances;

21 "(2) applicable laws, regulations, rules, and
22 policies on controlled substances, including the de-
23 gree to which misconceptions and concerns regarding
24 such laws, regulations, rules, and policies, or the en-

1 forcement thereof, may create barriers to patient ac-
2 cess to appropriate and effective pain care;
3 ''(3) interdisciplinary approaches to the delivery
4 of pain care, including delivery through specialized
5 centers providing comprehensive pain care treatment
6 expertise;
7 ''(4) cultural, linguistic, literacy, geographic,
8 and other barriers to care in underserved popu-
9 lations; and
10 ''(5) recent findings, developments, and im-
11 provements in the provision of pain care.
12 ''(c) EVALUATION OF PROGRAMS.—The Secretary
13 shall (directly or through grants or contracts) provide for
14 the evaluation of programs implemented under subsection
15 (a) in order to determine the effect of such programs on
16 knowledge and practice of pain care.
17 ''(d) PAIN CARE DEFINED.—For purposes of this
18 section the term 'pain care' means the assessment, diag-
19 nosis, treatment, or management of acute or chronic pain
20 regardless of causation or body location.
21 ''(e) AUTHORIZATION OF APPROPRIATIONS.—There
22 is authorized to be appropriated to carry out this section,
23 such sums as may be necessary for each of the fiscal years
24 2010 through 2012. Amounts appropriated under this
25 subsection shall remain available until expended.''.

SEC. 4306. FUNDING FOR CHILDHOOD OBESITY DEMONSTRATION PROJECT.

Section 1139A(e)(8) of the Social Security Act (42 U.S.C. 1320b–9a(e)(8)) is amended to read as follows:

"(8) APPROPRIATION.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to carry out this subsection, $25,000,000 for the period of fiscal years 2010 through 2014.".

Subtitle E—Miscellaneous Provisions

SEC. 4401. SENSE OF THE SENATE CONCERNING CBO SCORING.

(a) FINDING.—The Senate finds that the costs of prevention programs are difficult to estimate due in part because prevention initiatives are hard to measure and results may occur outside the 5 and 10 year budget windows.

(b) SENSE OF CONGRESS.—It is the sense of the Senate that Congress should work with the Congressional Budget Office to develop better methodologies for scoring progress to be made in prevention and wellness programs.

SEC. 4402. EFFECTIVENESS OF FEDERAL HEALTH AND WELLNESS INITIATIVES.

To determine whether existing Federal health and wellness initiatives are effective in achieving their stated

goals, the Secretary of Health and Human Services shall—

(1) conduct an evaluation of such programs as they relate to changes in health status of the American public and specifically on the health status of the Federal workforce, including absenteeism of employees, the productivity of employees, the rate of workplace injury, and the medical costs incurred by employees, and health conditions, including workplace fitness, healthy food and beverages, and incentives in the Federal Employee Health Benefits Program; and

(2) submit to Congress a report concerning such evaluation, which shall include conclusions concerning the reasons that such existing programs have proven successful or not successful and what factors contributed to such conclusions.

TITLE V—HEALTH CARE WORKFORCE

Subtitle A—Purpose and Definitions

SEC. 5001. PURPOSE.

The purpose of this title is to improve access to and the delivery of health care services for all individuals, par-

1 ticularly low income, underserved, uninsured, minority,
2 health disparity, and rural populations by—
3 (1) gathering and assessing comprehensive data
4 in order for the health care workforce to meet the
5 health care needs of individuals, including research
6 on the supply, demand, distribution, diversity, and
7 skills needs of the health care workforce;
8 (2) increasing the supply of a qualified health
9 care workforce to improve access to and the delivery
10 of health care services for all individuals;
11 (3) enhancing health care workforce education
12 and training to improve access to and the delivery
13 of health care services for all individuals; and
14 (4) providing support to the existing health care
15 workforce to improve access to and the delivery of
16 health care services for all individuals.
17 **SEC. 5002. DEFINITIONS.**
18 (a) THIS TITLE.—In this title:
19 (1) ALLIED HEALTH PROFESSIONAL.—The
20 term ''allied health professional'' means an allied
21 health professional as defined in section 799B(5) of
22 the Public Heath Service Act (42 U.S.C. 295p(5))
23 who—

(A) has graduated and received an allied health professions degree or certificate from an institution of higher education; and

(B) is employed with a Federal, State, local or tribal public health agency, or in a setting where patients might require health care services, including acute care facilities, ambulatory care facilities, personal residences, and other settings located in health professional shortage areas, medically underserved areas, or medically underserved populations, as recognized by the Secretary of Health and Human Services.

(2) HEALTH CARE CAREER PATHWAY.—The term ''healthcare career pathway'' means a rigorous, engaging, and high quality set of courses and services that—

(A) includes an articulated sequence of academic and career courses, including 21st century skills;

(B) is aligned with the needs of healthcare industries in a region or State;

(C) prepares students for entry into the full range of postsecondary education options,

including registered apprenticeships, and careers;

(D) provides academic and career counseling in student-to-counselor ratios that allow students to make informed decisions about academic and career options;

(E) meets State academic standards, State requirements for secondary school graduation and is aligned with requirements for entry into postsecondary education, and applicable industry standards; and

(F) leads to 2 or more credentials, including—

(i) a secondary school diploma; and

(ii) a postsecondary degree, an apprenticeship or other occupational certification, a certificate, or a license.

(3) INSTITUTION OF HIGHER EDUCATION.—The term ''institution of higher education'' has the meaning given the term in sections 101 and 102 of the Higher Education Act of 1965 (20 U.S.C. 1001 and 1002).

(4) LOW INCOME INDIVIDUAL, STATE WORKFORCE INVESTMENT BOARD, AND LOCAL WORKFORCE INVESTMENT BOARD.—

(A) LOW-INCOME INDIVIDUAL.—The term ''low-income individual'' has the meaning given that term in section 101 of the Workforce investment Act of 1998 (29 U.S.C. 2801).

(B) STATE WORKFORCE INVESTMENT BOARD; LOCAL WORKFORCE INVESTMENT BOARD.—The terms ''State workforce investment board'' and ''local workforce investment board'', refer to a State workforce investment board established under section 111 of the Workforce Investment Act of 1998 (29 U.S.C. 2821) and a local workforce investment board established under section 117 of such Act (29 U.S.C. 2832), respectively.

(5) POSTSECONDARY EDUCATION.—The term ''postsecondary education'' means—

(A) a 4-year program of instruction, or not less than a 1-year program of instruction that is acceptable for credit toward an associate or a baccalaureate degree, offered by an institution of higher education; or

(B) a certificate or registered apprenticeship program at the postsecondary level offered by an institution of higher education or a nonprofit educational institution.

(6) REGISTERED APPRENTICESHIP PROGRAM.—The term ''registered apprenticeship program'' means an industry skills training program at the postsecondary level that combines technical and theoretical training through structure on the job learning with related instruction (in a classroom or through distance learning) while an individual is employed, working under the direction of qualified personnel or a mentor, and earning incremental wage increases aligned to enhance job proficiency, resulting in the acquisition of a nationally recognized and portable certificate, under a plan approved by the Office of Apprenticeship or a State agency recognized by the Department of Labor.

(b) TITLE VII OF THE PUBLIC HEALTH SERVICE ACT.—Section 799B of the Public Health Service Act (42 U.S.C. 295p) is amended—

(1) by striking paragraph (3) and inserting the following:

''(3) PHYSICIAN ASSISTANT EDUCATION PROGRAM.—The term 'physician assistant education program' means an educational program in a public or private institution in a State that—

''(A) has as its objective the education of individuals who, upon completion of their stud-

ies in the program, be qualified to provide primary care medical services with the supervision of a physician; and

"(B) is accredited by the Accreditation Review Commission on Education for the Physician Assistant."; and

(2) by adding at the end the following:

"(12) AREA HEALTH EDUCATION CENTER.—The term 'area health education center' means a public or nonprofit private organization that has a cooperative agreement or contract in effect with an entity that has received an award under subsection (a)(1) or (a)(2) of section 751, satisfies the requirements in section 751(d)(1), and has as one of its principal functions the operation of an area health education center. Appropriate organizations may include hospitals, health organizations with accredited primary care training programs, accredited physician assistant educational programs associated with a college or university, and universities or colleges not operating a school of medicine or osteopathic medicine.

"(13) AREA HEALTH EDUCATION CENTER PROGRAM.—The term 'area health education center program' means cooperative program consisting of an

1 entity that has received an award under subsection
2 (a)(1) or (a)(2) of section 751 for the purpose of
3 planning, developing, operating, and evaluating an
4 area health education center program and one or
5 more area health education centers, which carries
6 out the required activities described in section
7 751(c), satisfies the program requirements in such
8 section, has as one of its principal functions identi-
9 fying and implementing strategies and activities that
10 address health care workforce needs in its service
11 area, in coordination with the local workforce invest-
12 ment boards.

13 "(14) CLINICAL SOCIAL WORKER.—The term
14 'clinical social worker' has the meaning given the
15 term in section 1861(hh)(1) of the Social Security
16 Act (42 U.S.C. 1395x(hh)(1)).

17 "(15) CULTURAL COMPETENCY.—The term
18 'cultural competency' shall be defined by the Sec-
19 retary in a manner consistent with section
20 1707(d)(3).

21 "(16) DIRECT CARE WORKER.—The term 'di-
22 rect care worker' has the meaning given that term
23 in the 2010 Standard Occupational Classifications of
24 the Department of Labor for Home Health Aides
25 [31–1011], Psychiatric Aides [31–1013], Nursing

Assistants [31–1014], and Personal Care Aides [39–9021].

"(17) FEDERALLY QUALIFIED HEALTH CENTER.—The term 'Federally qualified health center' has the meaning given that term in section 1861(aa) of the Social Security Act (42 U.S.C. 1395x(aa)).

"(18) FRONTIER HEALTH PROFESSIONAL SHORTAGE AREA.—The term 'frontier health professional shortage area' means an area—

"(A) with a population density less than 6 persons per square mile within the service area; and

"(B) with respect to which the distance or time for the population to access care is excessive.

"(19) GRADUATE PSYCHOLOGY.—The term 'graduate psychology' means an accredited program in professional psychology.

"(20) HEALTH DISPARITY POPULATION.—The term 'health disparity population' has the meaning given such term in section 903(d)(1).

"(21) HEALTH LITERACY.—The term 'health literacy' means the degree to which an individual has the capacity to obtain, communicate, process, and

1 understand health information and services in order
2 to make appropriate health decisions.

3 ''(22) MENTAL HEALTH SERVICE PROFES-
4 SIONAL.—The term 'mental health service profes-
5 sional' means an individual with a graduate or post-
6 graduate degree from an accredited institution of
7 higher education in psychiatry, psychology, school
8 psychology, behavioral pediatrics, psychiatric nurs-
9 ing, social work, school social work, substance abuse
10 disorder prevention and treatment, marriage and
11 family counseling, school counseling, or professional
12 counseling.

13 ''(23) ONE-STOP DELIVERY SYSTEM CENTER.—
14 The term 'one-stop delivery system' means a one-
15 stop delivery system described in section 134(c) of
16 the Workforce Investment Act of 1998 (29 U.S.C.
17 2864(c)).

18 ''(24) PARAPROFESSIONAL CHILD AND ADOLES-
19 CENT MENTAL HEALTH WORKER.—The term 'para-
20 professional child and adolescent mental health
21 worker' means an individual who is not a mental or
22 behavioral health service professional, but who works
23 at the first stage of contact with children and fami-
24 lies who are seeking mental or behavioral health

1 services, including substance abuse prevention and
2 treatment services.
3 "(25) RACIAL AND ETHNIC MINORITY GROUP;
4 RACIAL AND ETHNIC MINORITY POPULATION.—The
5 terms 'racial and ethnic minority group' and 'racial
6 and ethnic minority population' have the meaning
7 given the term 'racial and ethnic minority group' in
8 section 1707.
9 "(26) RURAL HEALTH CLINIC.—The term
10 'rural health clinic' has the meaning given that term
11 in section 1861(aa) of the Social Security Act (42
12 U.S.C. 1395x(aa)).".
13 (c) TITLE VIII OF THE PUBLIC HEALTH SERVICE
14 ACT.—Section 801 of the Public Health Service Act (42
15 U.S.C. 296) is amended—
16 (1) in paragraph (2)—
17 (A) by striking "means a" and inserting
18 "means an accredited (as defined in paragraph
19 6)"; and
20 (B) by striking the period as inserting the
21 following: "where graduates are—
22 "(A) authorized to sit for the National
23 Council Licensure EXamination-Registered
24 Nurse (NCLEX-RN); or

"(B) licensed registered nurses who will receive a graduate or equivalent degree or training to become an advanced education nurse as defined by section 811(b)."; and

(2) by adding at the end the following:

"(16) ACCELERATED NURSING DEGREE PROGRAM.—The term 'accelerated nursing degree program' means a program of education in professional nursing offered by an accredited school of nursing in which an individual holding a bachelors degree in another discipline receives a BSN or MSN degree in an accelerated time frame as determined by the accredited school of nursing.

"(17) BRIDGE OR DEGREE COMPLETION PROGRAM.—The term 'bridge or degree completion program' means a program of education in professional nursing offered by an accredited school of nursing, as defined in paragraph (2), that leads to a baccalaureate degree in nursing. Such programs may include, Registered Nurse (RN) to Bachelor's of Science of Nursing (BSN) programs, RN to MSN (Master of Science of Nursing) programs, or BSN to Doctoral programs.".

Subtitle B—Innovations in the Health Care Workforce

SEC. 5101. NATIONAL HEALTH CARE WORKFORCE COMMISSION.

(a) PURPOSE.—It is the purpose of this section to establish a National Health Care Workforce Commission that—

(1) serves as a national resource for Congress, the President, States, and localities;

(2) communicates and coordinates with the Departments of Health and Human Services, Labor, Veterans Affairs, Homeland Security, and Education on related activities administered by one or more of such Departments;

(3) develops and commissions evaluations of education and training activities to determine whether the demand for health care workers is being met;

(4) identifies barriers to improved coordination at the Federal, State, and local levels and recommend ways to address such barriers; and

(5) encourages innovations to address population needs, constant changes in technology, and other environmental factors.

(b) ESTABLISHMENT.—There is hereby established the National Health Care Workforce Commission (in this section referred to as the ''Commission'').

(c) MEMBERSHIP.—

(1) NUMBER AND APPOINTMENT.—The Commission shall be composed of 15 members to be appointed by the Comptroller General, without regard to section 5 of the Federal Advisory Committee Act (5 U.S.C. App.).

(2) QUALIFICATIONS.—

(A) IN GENERAL.—The membership of the Commission shall include individuals—

(i) with national recognition for their expertise in health care labor market analysis, including health care workforce analysis; health care finance and economics; health care facility management; health care plans and integrated delivery systems; health care workforce education and training; health care philanthropy; providers of health care services; and other related fields; and

(ii) who will provide a combination of professional perspectives, broad geographic representation, and a balance between

1 urban, suburban, rural, and frontier rep-
2 resentatives.
3 (B) INCLUSION.—
4 (i) IN GENERAL.—The membership of
5 the Commission shall include no less than
6 one representative of—
7 (I) the health care workforce and
8 health professionals;
9 (II) employers;
10 (III) third-party payers;
11 (IV) individuals skilled in the
12 conduct and interpretation of health
13 care services and health economics re-
14 search;
15 (V) representatives of consumers;
16 (VI) labor unions;
17 (VII) State or local workforce in-
18 vestment boards; and
19 (VIII) educational institutions
20 (which may include elementary and
21 secondary institutions, institutions of
22 higher education, including 2 and 4
23 year institutions, or registered ap-
24 prenticeship programs).

(ii) ADDITIONAL MEMBERS.—The remaining membership may include additional representatives from clause (i) and other individuals as determined appropriate by the Comptroller General of the United States.

(C) MAJORITY NON-PROVIDERS.—Individuals who are directly involved in health professions education or practice shall not constitute a majority of the membership of the Commission.

(D) ETHICAL DISCLOSURE.—The Comptroller General shall establish a system for public disclosure by members of the Commission of financial and other potential conflicts of interest relating to such members. Members of the Commission shall be treated as employees of Congress for purposes of applying title I of the Ethics in Government Act of 1978. Members of the Commission shall not be treated as special government employees under title 18, United States Code.

(3) TERMS.—

(A) IN GENERAL.—The terms of members of the Commission shall be for 3 years except

that the Comptroller General shall designate staggered terms for the members first appointed.

(B) VACANCIES.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in the Commission shall be filled in the manner in which the original appointment was made.

(C) INITIAL APPOINTMENTS.—The Comptroller General shall make initial appointments of members to the Commission not later than September 30, 2010.

(4) COMPENSATION.—While serving on the business of the Commission (including travel time), a member of the Commission shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of tile 5, United States Code, and while so serving away from home and the member's regular place of business, a member may be allowed travel expenses, as authorized by the Chair-

man of the Commission. Physicians serving as personnel of the Commission may be provided a physician comparability allowance by the Commission in the same manner as Government physicians may be provided such an allowance by an agency under section 5948 of title 5, United States Code, and for such purpose subsection (i) of such section shall apply to the Commission in the same manner as it applies to the Tennessee Valley Authority. For purposes of pay (other than pay of members of the Commission) and employment benefits, rights, and privileges, all personnel of the Commission shall be treated as if they were employees of the United States Senate. Personnel of the Commission shall not be treated as employees of the Government Accountability Office for any purpose.

(5) CHAIRMAN, VICE CHAIRMAN.—The Comptroller General shall designate a member of the Commission, at the time of appointment of the member, as Chairman and a member as Vice Chairman for that term of appointment, except that in the case of vacancy of the chairmanship or vice chairmanship, the Comptroller General may designate another member for the remainder of that member's term.

1 (6) MEETINGS.—The Commission shall meet at
2 the call of the chairman, but no less frequently than
3 on a quarterly basis.
4 (d) DUTIES.—
5 (1) RECOGNITION, DISSEMINATION, AND COM-
6 MUNICATION.—The Commission shall—
7 (A) recognize efforts of Federal, State, and
8 local partnerships to develop and offer health
9 care career pathways of proven effectiveness;
10 (B) disseminate information on promising
11 retention practices for health care professionals;
12 and
13 (C) communicate information on important
14 policies and practices that affect the recruit-
15 ment, education and training, and retention of
16 the health care workforce.
17 (2) REVIEW OF HEALTH CARE WORKFORCE
18 AND ANNUAL REPORTS.—In order to develop a fis-
19 cally sustainable integrated workforce that supports
20 a high-quality, readily accessible health care delivery
21 system that meets the needs of patients and popu-
22 lations, the Commission, in consultation with rel-
23 evant Federal, State, and local agencies, shall—

(A) review current and projected health care workforce supply and demand, including the topics described in paragraph (3);

(B) make recommendations to Congress and the Administration concerning national health care workforce priorities, goals, and policies;

(C) by not later than October 1 of each year (beginning with 2011), submit a report to Congress and the Administration containing the results of such reviews and recommendations concerning related policies; and

(D) by not later than April 1 of each year (beginning with 2011), submit a report to Congress and the Administration containing a review of, and recommendations on, at a minimum one high priority area as described in paragraph (4).

(3) SPECIFIC TOPICS TO BE REVIEWED.—The topics described in this paragraph include—

(A) current health care workforce supply and distribution, including demographics, skill sets, and demands, with projected demands during the subsequent 10 and 25 year periods;

(B) health care workforce education and training capacity, including the number of students who have completed education and training, including registered apprenticeships; the number of qualified faculty; the education and training infrastructure; and the education and training demands, with projected demands during the subsequent 10 and 25 year periods;

(C) the education loan and grant programs in titles VII and VIII of the Public Health Service Act (42 U.S.C. 292 et seq. and 296 et seq.), with recommendations on whether such programs should become part of the Higher Education Act of 1965 (20 U.S.C. 1001 et seq);

(D) the implications of new and existing Federal policies which affect the health care workforce, including Medicare and Medicaid graduate medical education policies, titles VII and VIII of the Public Health Service Act (42 U.S.C. 292 et seq. and 296 et seq.), the National Health Service Corps (with recommendations for aligning such programs with national health workforce priorities and goals), and other health care workforce programs, including

1 those supported through the Workforce Invest-
2 ment Act of 1998 (29 U.S.C. 2801 et seq.), the
3 Carl D. Perkins Career and Technical Edu-
4 cation Act of 2006 (20 U.S.C. 2301 et seq.),
5 the Higher Education Act of 1965 (20 U.S.C.
6 1001 et seq.), and any other Federal health
7 care workforce programs;
8 (E) the health care workforce needs of spe-
9 cial populations, such as minorities, rural popu-
10 lations, medically underserved populations, gen-
11 der specific needs, individuals with disabilities,
12 and geriatric and pediatric populations with
13 recommendations for new and existing Federal
14 policies to meet the needs of these special popu-
15 lations; and
16 (F) recommendations creating or revising
17 national loan repayment programs and scholar-
18 ship programs to require low-income, minority
19 medical students to serve in their home commu-
20 nities, if designated as medical underserved
21 community.
22 (4) HIGH PRIORITY AREAS.—
23 (A) IN GENERAL.—The initial high priority
24 topics described in this paragraph include each
25 of the following:

(i) Integrated health care workforce planning that identifies health care professional skills needed and maximizes the skill sets of health care professionals across disciplines.

(ii) An analysis of the nature, scopes of practice, and demands for health care workers in the enhanced information technology and management workplace.

(iii) An analysis of how to align Medicare and Medicaid graduate medical education policies with national workforce goals.

(iv) The education and training capacity, projected demands, and integration with the health care delivery system of each of the following:

(I) Nursing workforce capacity at all levels.

(II) Oral health care workforce capacity at all levels.

(III) Mental and behavioral health care workforce capacity at all levels.

(IV) Allied health and public health care workforce capacity at all levels.

(V) Emergency medical service workforce capacity, including the retention and recruitment of the volunteer workforce, at all levels.

(VI) The geographic distribution of health care providers as compared to the identified health care workforce needs of States and regions.

(B) FUTURE DETERMINATIONS.—The Commission may require that additional topics be included under subparagraph (A). The appropriate committees of Congress may recommend to the Commission the inclusion of other topics for health care workforce development areas that require special attention.

(5) GRANT PROGRAM.—The Commission shall—

(A) review implementation progress reports on, and report to Congress about, the State Health Care Workforce Development Grant program established in section 5102;

(B) in collaboration with the Department of Labor and in coordination with the Department of Education and other relevant Federal agencies, make recommendations to the fiscal and administrative agent under section 5102(b) for grant recipients under section 5102;

(C) assess the implementation of the grants under such section; and

(D) collect performance and report information, including identified models and best practices, on grants from the fiscal and administrative agent under such section and distribute this information to Congress, relevant Federal agencies, and to the public.

(6) STUDY.—The Commission shall study effective mechanisms for financing education and training for careers in health care, including public health and allied health.

(7) RECOMMENDATIONS.—The Commission shall submit recommendations to Congress, the Department of Labor, and the Department of Health and Human Services about improving safety, health, and worker protections in the workplace for the health care workforce.

1 (8) ASSESSMENT.—The Commission shall as-
2 sess and receive reports from the National Center
3 for Health Care Workforce Analysis established
4 under section 761(b) of the Public Service Health
5 Act (as amended by section 5103).
6 (e) CONSULTATION WITH FEDERAL, STATE, AND
7 LOCAL AGENCIES, CONGRESS, AND OTHER ORGANIZA-
8 TIONS.—
9 (1) IN GENERAL.—The Commission shall con-
10 sult with Federal agencies (including the Depart-
11 ments of Health and Human Services, Labor, Edu-
12 cation, Commerce, Agriculture, Defense, and Vet-
13 erans Affairs and the Environmental Protection
14 Agency), Congress, the Medicare Payment Advisory
15 Commission, the Medicaid and CHIP Payment and
16 Access Commission, and, to the extent practicable,
17 with State and local agencies, Indian tribes, vol-
18 untary health care organizations, professional soci-
19 eties, and other relevant public-private health care
20 partnerships.
21 (2) OBTAINING OFFICIAL DATA.—The Commis-
22 sion, consistent with established privacy rules, may
23 secure directly from any department or agency of
24 the Executive Branch information necessary to en-
25 able the Commission to carry out this section.

(3) DETAIL OF FEDERAL GOVERNMENT EMPLOYEES.—An employee of the Federal Government may be detailed to the Commission without reimbursement. The detail of such an employee shall be without interruption or loss of civil service status.

(f) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—Subject to such review as the Comptroller General of the United States determines to be necessary to ensure the efficient administration of the Commission, the Commission may—

(1) employ and fix the compensation of an executive director that shall not exceed the rate of basic pay payable for level V of the Executive Schedule and such other personnel as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

(2) seek such assistance and support as may be required in the performance of its duties from appropriate Federal departments and agencies;

(3) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Commission (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));

(4) make advance, progress, and other payments which relate to the work of the Commission;

(5) provide transportation and subsistence for persons serving without compensation; and

(6) prescribe such rules and regulations as the Commission determines to be necessary with respect to the internal organization and operation of the Commission.

(g) POWERS.—

(1) DATA COLLECTION.—In order to carry out its functions under this section, the Commission shall—

(A) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this section, including coordination with the Bureau of Labor Statistics;

(B) carry out, or award grants or contracts for the carrying out of, original research and development, where existing information is inadequate, and

(C) adopt procedures allowing interested parties to submit information for the Commis-

sion's use in making reports and recommendations.

(2) ACCESS OF THE GOVERNMENT ACCOUNTABILITY OFFICE TO INFORMATION.—The Comptroller General of the United States shall have unrestricted access to all deliberations, records, and data of the Commission, immediately upon request.

(3) PERIODIC AUDIT.—The Commission shall be subject to periodic audit by an independent public accountant under contract to the Commission.

(h) AUTHORIZATION OF APPROPRIATIONS.—

(1) REQUEST FOR APPROPRIATIONS.—The Commission shall submit requests for appropriations in the same manner as the Comptroller General of the United States submits requests for appropriations. Amounts so appropriated for the Commission shall be separate from amounts appropriated for the Comptroller General.

(2) AUTHORIZATION.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

(3) GIFTS AND SERVICES.—The Commission may not accept gifts, bequeaths, or donations of property, but may accept and use donations of services for purposes of carrying out this section.

1 (i) DEFINITIONS.—In this section:

2 (1) HEALTH CARE WORKFORCE.—The term
3 ''health care workforce'' includes all health care pro-
4 viders with direct patient care and support respon-
5 sibilities, such as physicians, nurses, nurse practi-
6 tioners, primary care providers, preventive medicine
7 physicians, optometrists, ophthalmologists, physician
8 assistants, pharmacists, dentists, dental hygienists,
9 and other oral healthcare professionals, allied health
10 professionals, doctors of chiropractic, community
11 health workers, health care paraprofessionals, direct
12 care workers, psychologists and other behavioral and
13 mental health professionals (including substance
14 abuse prevention and treatment providers), social
15 workers, physical and occupational therapists, cer-
16 tified nurse midwives, podiatrists, the EMS work-
17 force (including professional and volunteer ambu-
18 lance personnel and firefighters who perform emer-
19 gency medical services), licensed complementary and
20 alternative medicine providers, integrative health
21 practitioners, public health professionals, and any
22 other health professional that the Comptroller Gen-
23 eral of the United States determines appropriate.

24 (2) HEALTH PROFESSIONALS.—The term
25 ''health professionals'' includes—

1 (A) dentists, dental hygienists, primary
2 care providers, specialty physicians, nurses,
3 nurse practitioners, physician assistants, psy-
4 chologists and other behavioral and mental
5 health professionals (including substance abuse
6 prevention and treatment providers), social
7 workers, physical and occupational therapists,
8 public health professionals, clinical pharmacists,
9 allied health professionals, doctors of chiro-
10 practic, community health workers, school
11 nurses, certified nurse midwives, podiatrists, li-
12 censed complementary and alternative medicine
13 providers, the EMS workforce (including profes-
14 sional and volunteer ambulance personnel and
15 firefighters who perform emergency medical
16 services), and integrative health practitioners;
17 (B) national representatives of health pro-
18 fessionals;
19 (C) representatives of schools of medicine,
20 osteopathy, nursing, dentistry, optometry, phar-
21 macy, chiropractic, allied health, educational
22 programs for public health professionals, behav-
23 ioral and mental health professionals (as so de-
24 fined), social workers, pharmacists, physical
25 and occupational therapists, oral health care in-

1 dustry dentistry and dental hygiene, and physi-
2 cian assistants;
3 (D) representatives of public and private
4 teaching hospitals, and ambulatory health facili-
5 ties, including Federal medical facilities; and
6 (E) any other health professional the
7 Comptroller General of the United States deter-
8 mines appropriate.

9 **SEC. 5102. STATE HEALTH CARE WORKFORCE DEVELOP-**
10 **MENT GRANTS.**

11 (a) ESTABLISHMENT.—There is established a com-
12 petitive health care workforce development grant program
13 (referred to in this section as the ''program'') for the pur-
14 pose of enabling State partnerships to complete com-
15 prehensive planning and to carry out activities leading to
16 coherent and comprehensive health care workforce devel-
17 opment strategies at the State and local levels.

18 (b) FISCAL AND ADMINISTRATIVE AGENT.—The
19 Health Resources and Services Administration of the De-
20 partment of Health and Human Services (referred to in
21 this section as the ''Administration'') shall be the fiscal
22 and administrative agent for the grants awarded under
23 this section. The Administration is authorized to carry out
24 the program, in consultation with the National Health
25 Care Workforce Commission (referred to in this section

as the ''Commission''), which shall review reports on the development, implementation, and evaluation activities of the grant program, including—

(1) administering the grants;

(2) providing technical assistance to grantees; and

(3) reporting performance information to the Commission.

(c) PLANNING GRANTS.—

(1) AMOUNT AND DURATION.—A planning grant shall be awarded under this subsection for a period of not more than one year and the maximum award may not be more than $150,000.

(2) ELIGIBILITY.—To be eligible to receive a planning grant, an entity shall be an eligible partnership. An eligible partnership shall be a State workforce investment board, if it includes or modifies the members to include at least one representative from each of the following: health care employer, labor organization, a public 2-year institution of higher education, a public 4-year institution of higher education, the recognized State federation of labor, the State public secondary education agency, the State P–16 or P–20 Council if such a council exists, and a philanthropic organization that is actively

engaged in providing learning, mentoring, and work opportunities to recruit, educate, and train individuals for, and retain individuals in, careers in health care and related industries.

(3) FISCAL AND ADMINISTRATIVE AGENT.—The Governor of the State receiving a planning grant has the authority to appoint a fiscal and an administrative agency for the partnership.

(4) APPLICATION.—Each State partnership desiring a planning grant shall submit an application to the Administrator of the Administration at such time and in such manner, and accompanied by such information as the Administrator may reasonable require. Each application submitted for a planning grant shall describe the members of the State partnership, the activities for which assistance is sought, the proposed performance benchmarks to be used to measure progress under the planning grant, a budget for use of the funds to complete the required activities described in paragraph (5), and such additional assurance and information as the Administrator determines to be essential to ensure compliance with the grant program requirements.

1 (5) REQUIRED ACTIVITIES.—A State partner-
2 ship receiving a planning grant shall carry out the
3 following:
4 (A) Analyze State labor market informa-
5 tion in order to create health care career path-
6 ways for students and adults, including dis-
7 located workers.
8 (B) Identify current and projected high de-
9 mand State or regional health care sectors for
10 purposes of planning career pathways.
11 (C) Identify existing Federal, State, and
12 private resources to recruit, educate or train,
13 and retain a skilled health care workforce and
14 strengthen partnerships.
15 (D) Describe the academic and health care
16 industry skill standards for high school gradua-
17 tion, for entry into postsecondary education,
18 and for various credentials and licensure.
19 (E) Describe State secondary and postsec-
20 ondary education and training policies, models,
21 or practices for the health care sector, including
22 career information and guidance counseling.
23 (F) Identify Federal or State policies or
24 rules to developing a coherent and comprehen-
25 sive health care workforce development strategy

and barriers and a plan to resolve these barriers.

(G) Participate in the Administration's evaluation and reporting activities.

(6) PERFORMANCE AND EVALUATION.—Before the State partnership receives a planning grant, such partnership and the Administrator of the Administration shall jointly determine the performance benchmarks that will be established for the purposes of the planning grant.

(7) MATCH.—Each State partnership receiving a planning grant shall provide an amount, in cash or in kind, that is not less that 15 percent of the amount of the grant, to carry out the activities supported by the grant. The matching requirement may be provided from funds available under other Federal, State, local or private sources to carry out the activities.

(8) REPORT.—

(A) REPORT TO ADMINISTRATION.—Not later than 1 year after a State partnership receives a planning grant, the partnership shall submit a report to the Administration on the State's performance of the activities under the grant, including the use of funds, including

matching funds, to carry out required activities, and a description of the progress of the State workforce investment board in meeting the performance benchmarks.

(B) REPORT TO CONGRESS.—The Administration shall submit a report to Congress analyzing the planning activities, performance, and fund utilization of each State grant recipient, including an identification of promising practices and a profile of the activities of each State grant recipient.

(d) IMPLEMENTATION GRANTS.—

(1) IN GENERAL.—The Administration shall—

(A) competitively award implementation grants to State partnerships to enable such partnerships to implement activities that will result in a coherent and comprehensive plan for health workforce development that will address current and projected workforce demands within the State; and

(B) inform the Commission and Congress about the awards made.

(2) DURATION.—An implementation grant shall be awarded for a period of no more than 2 years, except in those cases where the Administration de-

termines that the grantee is high performing and the activities supported by the grant warrant up to 1 additional year of funding.

(3) ELIGIBILITY.—To be eligible for an implementation grant, a State partnership shall have—

(A) received a planning grant under subsection (c) and completed all requirements of such grant; or

(B) completed a satisfactory application, including a plan to coordinate with required partners and complete the required activities during the 2 year period of the implementation grant.

(4) FISCAL AND ADMINISTRATIVE AGENT.—A State partnership receiving an implementation grant shall appoint a fiscal and an administration agent for the implementation of such grant.

(5) APPLICATION.—Each eligible State partnership desiring an implementation grant shall submit an application to the Administration at such time, in such manner, and accompanied by such information as the Administration may reasonably require. Each application submitted shall include—

(A) a description of the members of the State partnership;

(B) a description of how the State partnership completed the required activities under the planning grant, if applicable;

(C) a description of the activities for which implementation grant funds are sought, including grants to regions by the State partnership to advance coherent and comprehensive regional health care workforce planning activities;

(D) a description of how the State partnership will coordinate with required partners and complete the required partnership activities during the duration of an implementation grant;

(E) a budget proposal of the cost of the activities supported by the implementation grant and a timeline for the provision of matching funds required;

(F) proposed performance benchmarks to be used to assess and evaluate the progress of the partnership activities;

(G) a description of how the State partnership will collect data to report progress in grant activities; and

(H) such additional assurances as the Administration determines to be essential to ensure compliance with grant requirements.

(6) REQUIRED ACTIVITIES.—

(A) IN GENERAL.—A State partnership that receives an implementation grant may reserve not less than 60 percent of the grant funds to make grants to be competitively awarded by the State partnership, consistent with State procurement rules, to encourage regional partnerships to address health care workforce development needs and to promote innovative health care workforce career pathway activities, including career counseling, learning, and employment.

(B) ELIGIBLE PARTNERSHIP DUTIES.—An eligible State partnership receiving an implementation grant shall—

(i) identify and convene regional leadership to discuss opportunities to engage in statewide health care workforce development planning, including the potential use of competitive grants to improve the development, distribution, and diversity of the regional health care workforce; the align-

1 ment of curricula for health care careers;
2 and the access to quality career informa-
3 tion and guidance and education and train-
4 ing opportunities;
5 (ii) in consultation with key stake-
6 holders and regional leaders, take appro-
7 priate steps to reduce Federal, State, or
8 local barriers to a comprehensive and co-
9 herent strategy, including changes in State
10 or local policies to foster coherent and
11 comprehensive health care workforce devel-
12 opment activities, including health care ca-
13 reer pathways at the regional and State
14 levels, career planning information, re-
15 training for dislocated workers, and as ap-
16 propriate, requests for Federal program or
17 administrative waivers;
18 (iii) develop, disseminate, and review
19 with key stakeholders a preliminary state-
20 wide strategy that addresses short- and
21 long-term health care workforce develop-
22 ment supply versus demand;
23 (iv) convene State partnership mem-
24 bers on a regular basis, and at least on a
25 semiannual basis;

(v) assist leaders at the regional level to form partnerships, including technical assistance and capacity building activities;

(vi) collect and assess data on and report on the performance benchmarks selected by the State partnership and the Administration for implementation activities carried out by regional and State partnerships; and

(vii) participate in the Administration's evaluation and reporting activities.

(7) PERFORMANCE AND EVALUATION.—Before the State partnership receives an implementation grant, it and the Administrator shall jointly determine the performance benchmarks that shall be established for the purposes of the implementation grant.

(8) MATCH.—Each State partnership receiving an implementation grant shall provide an amount, in cash or in kind that is not less than 25 percent of the amount of the grant, to carry out the activities supported by the grant. The matching funds may be provided from funds available from other Federal, State, local, or private sources to carry out such activities.

(9) REPORTS.—

(A) REPORT TO ADMINISTRATION.—For each year of the implementation grant, the State partnership receiving the implementation grant shall submit a report to the Administration on the performance of the State of the grant activities, including a description of the use of the funds, including matched funds, to complete activities, and a description of the performance of the State partnership in meeting the performance benchmarks.

(B) REPORT TO CONGRESS.—The Administration shall submit a report to Congress analyzing implementation activities, performance, and fund utilization of the State grantees, including an identification of promising practices and a profile of the activities of each State grantee.

(e) AUTHORIZATION FOR APPROPRIATIONS.—

(1) PLANNING GRANTS.—There are authorized to be appropriated to award planning grants under subsection (c) $8,000,000 for fiscal year 2010, and such sums as may be necessary for each subsequent fiscal year.

(2) IMPLEMENTATION GRANTS.—There are authorized to be appropriated to award implementation grants under subsection (d), $150,000,000 for fiscal year 2010, and such sums as may be necessary for each subsequent fiscal year.

SEC. 5103. HEALTH CARE WORKFORCE ASSESSMENT.

(a) IN GENERAL.—Section 761 of the Public Health Service Act (42 U.S.C. 294m) is amended—

(1) by redesignating subsection (c) as subsection (e);

(2) by striking subsection (b) and inserting the following:

''(b) NATIONAL CENTER FOR HEALTH CARE WORKFORCE ANALYSIS.—

''(1) ESTABLISHMENT.—The Secretary shall establish the National Center for Health Workforce Analysis (referred to in this section as the 'National Center').

''(2) PURPOSES.—The National Center, in coordination to the extent practicable with the National Health Care Workforce Commission (established in section 5101 of the Patient Protection and Affordable Care Act), and relevant regional and State centers and agencies, shall—

"(A) provide for the development of information describing and analyzing the health care workforce and workforce related issues;

"(B) carry out the activities under section 792(a);

"(C) annually evaluate programs under this title;

"(D) develop and publish performance measures and benchmarks for programs under this title; and

"(E) establish, maintain, and publicize a national Internet registry of each grant awarded under this title and a database to collect data from longitudinal evaluations (as described in subsection (d)(2)) on performance measures (as developed under sections 749(d)(3), 757(d)(3), and 762(a)(3)).

"(3) COLLABORATION AND DATA SHARING.—

"(A) IN GENERAL.—The National Center shall collaborate with Federal agencies and relevant professional and educational organizations or societies for the purpose of linking data regarding grants awarded under this title.

"(B) CONTRACTS FOR HEALTH WORKFORCE ANALYSIS.—For the purpose of carrying

out the activities described in subparagraph (A), the National Center may enter into contracts with relevant professional and educational organizations or societies.

"(c) STATE AND REGIONAL CENTERS FOR HEALTH WORKFORCE ANALYSIS.—

"(1) IN GENERAL.—The Secretary shall award grants to, or enter into contracts with, eligible entities for purposes of—

"(A) collecting, analyzing, and reporting data regarding programs under this title to the National Center and to the public; and

"(B) providing technical assistance to local and regional entities on the collection, analysis, and reporting of data.

"(2) ELIGIBLE ENTITIES.—To be eligible for a grant or contract under this subsection, an entity shall—

"(A) be a State, a State workforce investment board, a public health or health professions school, an academic health center, or an appropriate public or private nonprofit entity; and

"(B) submit to the Secretary an application at such time, in such manner, and con-

taining such information as the Secretary may require.

"(d) INCREASE IN GRANTS FOR LONGITUDINAL EVALUATIONS.—

"(1) IN GENERAL.—The Secretary shall increase the amount awarded to an eligible entity under this title for a longitudinal evaluation of individuals who have received education, training, or financial assistance from programs under this title.

"(2) CAPABILITY.—A longitudinal evaluation shall be capable of—

"(A) studying practice patterns; and

"(B) collecting and reporting data on performance measures developed under sections 749(d)(3), 757(d)(3), and 762(a)(3).

"(3) GUIDELINES.—A longitudinal evaluation shall comply with guidelines issued under sections 749(d)(4), 757(d)(4), and 762(a)(4).

"(4) ELIGIBLE ENTITIES.—To be eligible to obtain an increase under this section, an entity shall be a recipient of a grant or contract under this title."; and

(3) in subsection (e), as so redesignated—

(A) by striking paragraph (1) and inserting the following:

"(1) IN GENERAL.—

"(A) NATIONAL CENTER.—To carry out subsection (b), there are authorized to be appropriated $7,500,000 for each of fiscal years 2010 through 2014.

"(B) STATE AND REGIONAL CENTERS.—To carry out subsection (c), there are authorized to be appropriated $4,500,000 for each of fiscal years 2010 through 2014.

"(C) GRANTS FOR LONGITUDINAL EVALUATIONS.—To carry out subsection (d), there are authorized to be appropriated such sums as may be necessary for fiscal years 2010 through 2014."; and

(4) in paragraph (2), by striking "subsection (a)" and inserting "paragraph (1)".

(b) TRANSFERS.—Not later than 180 days after the date of enactment of this Act, the responsibilities and resources of the National Center for Health Workforce Analysis, as in effect on the date before the date of enactment of this Act, shall be transferred to the National Center for Health Care Workforce Analysis established under section 761 of the Public Health Service Act, as amended by subsection (a).

(c) USE OF LONGITUDINAL EVALUATIONS.—Section 791(a)(1) of the Public Health Service Act (42 U.S.C. 295j(a)(1)) is amended—

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

(2) in subparagraph (B), by striking the period and inserting ''; or''; and

(3) by adding at the end the following:

''(C) utilizes a longitudinal evaluation (as described in section 761(d)(2)) and reports data from such system to the national workforce database (as established under section 761(b)(2)(E)).''.

(d) PERFORMANCE MEASURES; GUIDELINES FOR LONGITUDINAL EVALUATIONS.—

(1) ADVISORY COMMITTEE ON TRAINING IN PRIMARY CARE MEDICINE AND DENTISTRY.—Section 748(d) of the Public Health Service Act is amended—

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

(B) in paragraph (2), by striking the period and inserting a semicolon; and

(C) by adding at the end the following:

1 ''(3) develop, publish, and implement perform-
2 ance measures for programs under this part;
3 ''(4) develop and publish guidelines for longitu-
4 dinal evaluations (as described in section 761(d)(2))
5 for programs under this part; and
6 ''(5) recommend appropriation levels for pro-
7 grams under this part.''.
8 (2) ADVISORY COMMITTEE ON INTERDISCIPLI-
9 NARY, COMMUNITY-BASED LINKAGES.—Section
10 756(d) of the Public Health Service Act is amend-
11 ed—
12 (A) in paragraph (1), by striking ''and'' at
13 the end;
14 (B) in paragraph (2), by striking the pe-
15 riod and inserting a semicolon; and
16 (C) by adding at the end the following:
17 ''(3) develop, publish, and implement perform-
18 ance measures for programs under this part;
19 ''(4) develop and publish guidelines for longitu-
20 dinal evaluations (as described in section 761(d)(2))
21 for programs under this part; and
22 ''(5) recommend appropriation levels for pro-
23 grams under this part.''.

(3) ADVISORY COUNCIL ON GRADUATE MEDICAL EDUCATION.—Section 762(a) of the Public Health Service Act (42 U.S.C. 294o(a)) is amended—

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

(B) in paragraph (2), by striking the period and inserting a semicolon; and

(C) by adding at the end the following:

''(3) develop, publish, and implement performance measures for programs under this title, except for programs under part C or D;

''(4) develop and publish guidelines for longitudinal evaluations (as described in section 761(d)(2)) for programs under this title, except for programs under part C or D; and

''(5) recommend appropriation levels for programs under this title, except for programs under part C or D.''.

Subtitle C—Increasing the Supply of the Health Care Workforce

SEC. 5201. FEDERALLY SUPPORTED STUDENT LOAN FUNDS.

(a) MEDICAL SCHOOLS AND PRIMARY HEALTH CARE.—Section 723 of the Public Health Service Act (42 U.S.C. 292s) is amended—

(1) in subsection (a)—

(A) in paragraph (1), by striking subparagraph (B) and inserting the following:

''(B) to practice in such care for 10 years (including residency training in primary health care) or through the date on which the loan is repaid in full, whichever occurs first.''; and

(B) by striking paragraph (3) and inserting the following:

''(3) NONCOMPLIANCE BY STUDENT.—Each agreement entered into with a student pursuant to paragraph (1) shall provide that, if the student fails to comply with such agreement, the loan involved will begin to accrue interest at a rate of 2 percent per year greater than the rate at which the student would pay if compliant in such year.''; and

(2) by adding at the end the following:

''(d) SENSE OF CONGRESS.—It is the sense of Congress that funds repaid under the loan program under this section should not be transferred to the Treasury of the United States or otherwise used for any other purpose other than to carry out this section.''.

(b) STUDENT LOAN GUIDELINES.—The Secretary of Health and Human Services shall not require parental financial information for an independent student to determine financial need under section 723 of the Public

Health Service Act (42 U.S.C. 292s) and the determination of need for such information shall be at the discretion of applicable school loan officer. The Secretary shall amend guidelines issued by the Health Resources and Services Administration in accordance with the preceding sentence.

SEC. 5202. NURSING STUDENT LOAN PROGRAM.

(a) LOAN AGREEMENTS.—Section 836(a) of the Public Health Service Act (42 U.S.C. 297b(a)) is amended—

(1) by striking ''$2,500'' and inserting ''$3,300'';

(2) by striking ''$4,000'' and inserting ''$5,200''; and

(3) by striking ''$13,000'' and all that follows through the period and inserting ''$17,000 in the case of any student during fiscal years 2010 and 2011. After fiscal year 2011, such amounts shall be adjusted to provide for a cost-of-attendance increase for the yearly loan rate and the aggregate of the loans.''.

(b) LOAN PROVISIONS.—Section 836(b) of the Public Health Service Act (42 U.S.C. 297b(b)) is amended—

(1) in paragraph (1)(C), by striking ''1986'' and inserting ''2000''; and

1 (2) in paragraph (3), by striking ''the date of
2 enactment of the Nurse Training Amendments of
3 1979'' and inserting ''September 29, 1995''.

4 **SEC. 5203. HEALTH CARE WORKFORCE LOAN REPAYMENT**
5 **PROGRAMS.**

6 Part E of title VII of the Public Health Service Act
7 (42 U.S.C. 294n et seq.) is amended by adding at the end
8 the following:

9 **''Subpart 3—Recruitment and Retention Programs**

10 **''SEC. 775. INVESTMENT IN TOMORROW'S PEDIATRIC**
11 **HEALTH CARE WORKFORCE.**

12 ''(a) ESTABLISHMENT.—The Secretary shall estab-
13 lish and carry out a pediatric specialty loan repayment
14 program under which the eligible individual agrees to be
15 employed full-time for a specified period (which shall not
16 be less than 2 years) in providing pediatric medical sub-
17 specialty, pediatric surgical specialty, or child and adoles-
18 cent mental and behavioral health care, including sub-
19 stance abuse prevention and treatment services.

20 ''(b) PROGRAM ADMINISTRATION.—Through the pro-
21 gram established under this section, the Secretary shall
22 enter into contracts with qualified health professionals
23 under which—

24 ''(1) such qualified health professionals will
25 agree to provide pediatric medical subspecialty, pedi-

1 atric surgical specialty, or child and adolescent men-
2 tal and behavioral health care in an area with a
3 shortage of the specified pediatric subspecialty that
4 has a sufficient pediatric population to support such
5 pediatric subspecialty, as determined by the Sec-
6 retary; and

7 "(2) the Secretary agrees to make payments on
8 the principal and interest of undergraduate, grad-
9 uate, or graduate medical education loans of profes-
10 sionals described in paragraph (1) of not more than
11 $35,000 a year for each year of agreed upon service
12 under such paragraph for a period of not more than
13 3 years during the qualified health professional's—

14 "(A) participation in an accredited pedi-
15 atric medical subspecialty, pediatric surgical
16 specialty, or child and adolescent mental health
17 subspecialty residency or fellowship; or

18 "(B) employment as a pediatric medical
19 subspecialist, pediatric surgical specialist, or
20 child and adolescent mental health professional
21 serving an area or population described in such
22 paragraph.

23 "(c) IN GENERAL.—

24 "(1) ELIGIBLE INDIVIDUALS.—

1 "(A) PEDIATRIC MEDICAL SPECIALISTS
2 AND PEDIATRIC SURGICAL SPECIALISTS.—For
3 purposes of contracts with respect to pediatric
4 medical specialists and pediatric surgical spe-
5 cialists, the term 'qualified health professional'
6 means a licensed physician who—
7 "(i) is entering or receiving training
8 in an accredited pediatric medical sub-
9 specialty or pediatric surgical specialty
10 residency or fellowship; or
11 "(ii) has completed (but not prior to
12 the end of the calendar year in which this
13 section is enacted) the training described
14 in subparagraph (B).
15 "(B) CHILD AND ADOLESCENT MENTAL
16 AND BEHAVIORAL HEALTH.—For purposes of
17 contracts with respect to child and adolescent
18 mental and behavioral health care, the term
19 'qualified health professional' means a health
20 care professional who—
21 "(i) has received specialized training
22 or clinical experience in child and adoles-
23 cent mental health in psychiatry, psy-
24 chology, school psychology, behavioral pedi-
25 atrics, psychiatric nursing, social work,

1 school social work, substance abuse dis-
2 order prevention and treatment, marriage
3 and family therapy, school counseling, or
4 professional counseling;

5 ''(ii) has a license or certification in a
6 State to practice allopathic medicine, os-
7 teopathic medicine, psychology, school psy-
8 chology, psychiatric nursing, social work,
9 school social work, marriage and family
10 therapy, school counseling, or professional
11 counseling; or

12 ''(iii) is a mental health service pro-
13 fessional who completed (but not before
14 the end of the calendar year in which this
15 section is enacted) specialized training or
16 clinical experience in child and adolescent
17 mental health described in clause (i).

18 ''(2) ADDITIONAL ELIGIBILITY REQUIRE-
19 MENTS.—The Secretary may not enter into a con-
20 tract under this subsection with an eligible indi-
21 vidual unless—

22 ''(A) the individual agrees to work in, or
23 for a provider serving, a health professional
24 shortage area or medically underserved area, or
25 to serve a medically underserved population;

"(B) the individual is a United States citizen or a permanent legal United States resident; and

"(C) if the individual is enrolled in a graduate program, the program is accredited, and the individual has an acceptable level of academic standing (as determined by the Secretary).

"(d) PRIORITY.—In entering into contracts under this subsection, the Secretary shall give priority to applicants who—

"(1) are or will be working in a school or other pre-kindergarten, elementary, or secondary education setting;

"(2) have familiarity with evidence-based methods and cultural and linguistic competence health care services; and

"(3) demonstrate financial need.

"(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated $30,000,000 for each of fiscal years 2010 through 2014 to carry out subsection (c)(1)(A) and $20,000,000 for each of fiscal years 2010 through 2013 to carry out subsection (c)(1)(B).".

SEC. 5204. PUBLIC HEALTH WORKFORCE RECRUITMENT AND RETENTION PROGRAMS.

Part E of title VII of the Public Health Service Act (42 U.S.C. 294n et seq.), as amended by section 5203, is further amended by adding at the end the following:

"SEC. 776. PUBLIC HEALTH WORKFORCE LOAN REPAYMENT PROGRAM.

"(a) ESTABLISHMENT.—The Secretary shall establish the Public Health Workforce Loan Repayment Program (referred to in this section as the 'Program') to assure an adequate supply of public health professionals to eliminate critical public health workforce shortages in Federal, State, local, and tribal public health agencies.

"(b) ELIGIBILITY.—To be eligible to participate in the Program, an individual shall—

"(1)(A) be accepted for enrollment, or be enrolled, as a student in an accredited academic educational institution in a State or territory in the final year of a course of study or program leading to a public health or health professions degree or certificate; and have accepted employment with a Federal, State, local, or tribal public health agency, or a related training fellowship, as recognized by the Secretary, to commence upon graduation;

"(B)(i) have graduated, during the preceding 10-year period, from an accredited educational insti-

tution in a State or territory and received a public health or health professions degree or certificate; and

"(ii) be employed by, or have accepted employment with, a Federal, State, local, or tribal public health agency or a related training fellowship, as recognized by the Secretary;

"(2) be a United States citizen; and

"(3)(A) submit an application to the Secretary to participate in the Program;

"(B) execute a written contract as required in subsection (c); and

"(4) not have received, for the same service, a reduction of loan obligations under section 455(m), 428J, 428K, 428L, or 460 of the Higher Education Act of 1965.

"(c) CONTRACT.—The written contract (referred to in this section as the 'written contract') between the Secretary and an individual shall contain—

"(1) an agreement on the part of the Secretary that the Secretary will repay on behalf of the individual loans incurred by the individual in the pursuit of the relevant degree or certificate in accordance with the terms of the contract;

"(2) an agreement on the part of the individual that the individual will serve in the full-time employment of a Federal, State, local, or tribal public health agency or a related fellowship program in a position related to the course of study or program for which the contract was awarded for a period of time (referred to in this section as the 'period of obligated service') equal to the greater of—

"(A) 3 years; or

"(B) such longer period of time as determined appropriate by the Secretary and the individual;

"(3) an agreement, as appropriate, on the part of the individual to relocate to a priority service area (as determined by the Secretary) in exchange for an additional loan repayment incentive amount to be determined by the Secretary;

"(4) a provision that any financial obligation of the United States arising out of a contract entered into under this section and any obligation of the individual that is conditioned thereon, is contingent on funds being appropriated for loan repayments under this section;

"(5) a statement of the damages to which the United States is entitled, under this section for the individual's breach of the contract; and

"(6) such other statements of the rights and liabilities of the Secretary and of the individual, not inconsistent with this section.

"(d) PAYMENTS.—

"(1) IN GENERAL.—A loan repayment provided for an individual under a written contract under the Program shall consist of payment, in accordance with paragraph (2), on behalf of the individual of the principal, interest, and related expenses on government and commercial loans received by the individual regarding the undergraduate or graduate education of the individual (or both), which loans were made for tuition expenses incurred by the individual.

"(2) PAYMENTS FOR YEARS SERVED.—For each year of obligated service that an individual contracts to serve under subsection (c) the Secretary may pay up to $35,000 on behalf of the individual for loans described in paragraph (1). With respect to participants under the Program whose total eligible loans are less than $105,000, the Secretary shall pay an amount that does not exceed ⅓ of the eligi-

ble loan balance for each year of obligated service of the individual.

"(3) TAX LIABILITY.—For the purpose of providing reimbursements for tax liability resulting from payments under paragraph (2) on behalf of an individual, the Secretary shall, in addition to such payments, make payments to the individual in an amount not to exceed 39 percent of the total amount of loan repayments made for the taxable year involved.

"(e) POSTPONING OBLIGATED SERVICE.—With respect to an individual receiving a degree or certificate from a health professions or other related school, the date of the initiation of the period of obligated service may be postponed as approved by the Secretary.

"(f) BREACH OF CONTRACT.—An individual who fails to comply with the contract entered into under subsection (c) shall be subject to the same financial penalties as provided for under section 338E for breaches of loan repayment contracts under section 338B.

"(g) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $195,000,000 for fiscal year 2010, and such sums as may be necessary for each of fiscal years 2011 through 2015.".

SEC. 5205. ALLIED HEALTH WORKFORCE RECRUITMENT AND RETENTION PROGRAMS.

(a) PURPOSE.—The purpose of this section is to assure an adequate supply of allied health professionals to eliminate critical allied health workforce shortages in Federal, State, local, and tribal public health agencies or in settings where patients might require health care services, including acute care facilities, ambulatory care facilities, personal residences and other settings, as recognized by the Secretary of Health and Human Services by authorizing an Allied Health Loan Forgiveness Program.

(b) ALLIED HEALTH WORKFORCE RECRUITMENT AND RETENTION PROGRAM.—Section 428K of the Higher Education Act of 1965 (20 U.S.C. 1078–11) is amended—

(1) in subsection (b), by adding at the end the following:

"(18) ALLIED HEALTH PROFESSIONALS.—The individual is employed full-time as an allied health professional—

"(A) in a Federal, State, local, or tribal public health agency; or

"(B) in a setting where patients might require health care services, including acute care facilities, ambulatory care facilities, personal residences and other settings located in health

professional shortage areas, medically underserved areas, or medically underserved populations, as recognized by the Secretary of Health and Human Services.''; and

(2) in subsection (g)—

(A) by redesignating paragraphs (1) through (9) as paragraphs (2) through (10), respectively; and

(B) by inserting before paragraph (2) (as redesignated by subparagraph (A)) the following:

''(1) ALLIED HEALTH PROFESSIONAL.—The term 'allied health professional' means an allied health professional as defined in section 799B(5) of the Public Heath Service Act (42 U.S.C. 295p(5)) who—

''(A) has graduated and received an allied health professions degree or certificate from an institution of higher education; and

''(B) is employed with a Federal, State, local or tribal public health agency, or in a setting where patients might require health care services, including acute care facilities, ambulatory care facilities, personal residences and other settings located in health professional

shortage areas, medically underserved areas, or medically underserved populations, as recognized by the Secretary of Health and Human Services.''.

SEC. 5206. GRANTS FOR STATE AND LOCAL PROGRAMS.

(a) IN GENERAL.—Section 765(d) of the Public Health Service Act (42 U.S.C. 295(d)) is amended—

(1) in paragraph (7), by striking ''; or'' and inserting a semicolon;

(2) by redesignating paragraph (8) as paragraph (9); and

(3) by inserting after paragraph (7) the following:

''(8) public health workforce loan repayment programs; or''.

(b) TRAINING FOR MID-CAREER PUBLIC HEALTH PROFESSIONALS.—Part E of title VII of the Public Health Service Act (42 U.S.C. 294n et seq.), as amended by section 5204, is further amended by adding at the end the following:

''SEC. 777. TRAINING FOR MID-CAREER PUBLIC AND ALLIED HEALTH PROFESSIONALS.

''(a) IN GENERAL.—The Secretary may make grants to, or enter into contracts with, any eligible entity to award scholarships to eligible individuals to enroll in de-

gree or professional training programs for the purpose of enabling mid-career professionals in the public health and allied health workforce to receive additional training in the field of public health and allied health.

"(b) ELIGIBILITY.—

"(1) ELIGIBLE ENTITY.—The term 'eligible entity' indicates an accredited educational institution that offers a course of study, certificate program, or professional training program in public or allied health or a related discipline, as determined by the Secretary

"(2) ELIGIBLE INDIVIDUALS.—The term 'eligible individuals' includes those individuals employed in public and allied health positions at the Federal, State, tribal, or local level who are interested in retaining or upgrading their education.

"(c) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $60,000,000 for fiscal year 2010 and such sums as may be necessary for each of fiscal years 2011 through 2015. Fifty percent of appropriated funds shall be allotted to public health mid-career professionals and 50 percent shall be allotted to allied health mid-career professionals.".

SEC. 5207. FUNDING FOR NATIONAL HEALTH SERVICE CORPS.

Section 338H(a) of the Public Health Service Act (42 U.S.C. 254q(a)) is amended to read as follows:

''(a) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there is authorized to be appropriated, out of any funds in the Treasury not otherwise appropriated, the following:

''(1) For fiscal year 2010, $320,461,632.

''(2) For fiscal year 2011, $414,095,394.

''(3) For fiscal year 2012, $535,087,442.

''(4) For fiscal year 2013, $691,431,432.

''(5) For fiscal year 2014, $893,456,433.

''(6) For fiscal year 2015, $1,154,510,336.

''(7) For fiscal year 2016, and each subsequent fiscal year, the amount appropriated for the preceding fiscal year adjusted by the product of—

''(A) one plus the average percentage increase in the costs of health professions education during the prior fiscal year; and

''(B) one plus the average percentage change in the number of individuals residing in health professions shortage areas designated under section 333 during the prior fiscal year, relative to the number of individuals residing in such areas during the previous fiscal year.''.

SEC. 5208. NURSE-MANAGED HEALTH CLINICS.

(a) PURPOSE.—The purpose of this section is to fund the development and operation of nurse-managed health clinics.

(b) GRANTS.—Subpart 1 of part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.) is amended by inserting after section 330A the following:

"SEC. 330A–1. GRANTS TO NURSE–MANAGED HEALTH CLINICS.

"(a) DEFINITIONS.—

"(1) COMPREHENSIVE PRIMARY HEALTH CARE SERVICES.—In this section, the term 'comprehensive primary health care services' means the primary health services described in section 330(b)(1).

"(2) NURSE-MANAGED HEALTH CLINIC.—The term 'nurse-managed health clinic' means a nurse-practice arrangement, managed by advanced practice nurses, that provides primary care or wellness services to underserved or vulnerable populations and that is associated with a school, college, university or department of nursing, federally qualified health center, or independent nonprofit health or social services agency.

"(b) AUTHORITY TO AWARD GRANTS.—The Secretary shall award grants for the cost of the operation of

1 nurse-managed health clinics that meet the requirements
2 of this section.
3 "(c) APPLICATIONS.—To be eligible to receive a grant
4 under this section, an entity shall—
5 "(1) be an NMHC; and
6 "(2) submit to the Secretary an application at
7 such time, in such manner, and containing—
8 "(A) assurances that nurses are the major
9 providers of services at the NMHC and that at
10 least 1 advanced practice nurse holds an execu-
11 tive management position within the organiza-
12 tional structure of the NMHC;
13 "(B) an assurance that the NMHC will
14 continue providing comprehensive primary
15 health care services or wellness services without
16 regard to income or insurance status of the pa-
17 tient for the duration of the grant period; and
18 "(C) an assurance that, not later than 90
19 days of receiving a grant under this section, the
20 NMHC will establish a community advisory
21 committee, for which a majority of the members
22 shall be individuals who are served by the
23 NMHC.

"(d) GRANT AMOUNT.—The amount of any grant made under this section for any fiscal year shall be determined by the Secretary, taking into account—

"(1) the financial need of the NMHC, considering State, local, and other operational funding provided to the NMHC; and

"(2) other factors, as the Secretary determines appropriate.

"(e) AUTHORIZATION OF APPROPRIATIONS.—For the purposes of carrying out this section, there are authorized to be appropriated $50,000,000 for the fiscal year 2010 and such sums as may be necessary for each of the fiscal years 2011 through 2014.".

SEC. 5209. ELIMINATION OF CAP ON COMMISSIONED CORPS.

Section 202 of the Department of Health and Human Services Appropriations Act, 1993 (Public Law 102-394) is amended by striking "not to exceed 2,800".

SEC. 5210. ESTABLISHING A READY RESERVE CORPS.

Section 203 of the Public Health Service Act (42 U.S.C. 204) is amended to read as follows:

"SEC. 203. COMMISSIONED CORPS AND READY RESERVE CORPS.

"(a) ESTABLISHMENT.—

"(1) IN GENERAL.—There shall be in the Service a commissioned Regular Corps and a Ready Reserve Corps for service in time of national emergency.

"(2) REQUIREMENT.—All commissioned officers shall be citizens of the United States and shall be appointed without regard to the civil-service laws and compensated without regard to the Classification Act of 1923, as amended.

"(3) APPOINTMENT.—Commissioned officers of the Ready Reserve Corps shall be appointed by the President and commissioned officers of the Regular Corps shall be appointed by the President with the advice and consent of the Senate.

"(4) ACTIVE DUTY.—Commissioned officers of the Ready Reserve Corps shall at all times be subject to call to active duty by the Surgeon General, including active duty for the purpose of training.

"(5) WARRANT OFFICERS.—Warrant officers may be appointed to the Service for the purpose of providing support to the health and delivery systems maintained by the Service and any warrant officer appointed to the Service shall be considered for purposes of this Act and title 37, United States Code,

to be a commissioned officer within the Commissioned Corps of the Service.

"(b) ASSIMILATING RESERVE CORP OFFICERS INTO THE REGULAR CORPS.—Effective on the date of enactment of the Patient Protection and Affordable Care Act, all individuals classified as officers in the Reserve Corps under this section (as such section existed on the day before the date of enactment of such Act) and serving on active duty shall be deemed to be commissioned officers of the Regular Corps.

"(c) PURPOSE AND USE OF READY RESEARCH.—

"(1) PURPOSE.—The purpose of the Ready Reserve Corps is to fulfill the need to have additional Commissioned Corps personnel available on short notice (similar to the uniformed service's reserve program) to assist regular Commissioned Corps personnel to meet both routine public health and emergency response missions.

"(2) USES.—The Ready Reserve Corps shall—

"(A) participate in routine training to meet the general and specific needs of the Commissioned Corps;

"(B) be available and ready for involuntary calls to active duty during national emergencies

and public health crises, similar to the uniformed service reserve personnel;

"(C) be available for backfilling critical positions left vacant during deployment of active duty Commissioned Corps members, as well as for deployment to respond to public health emergencies, both foreign and domestic; and

"(D) be available for service assignment in isolated, hardship, and medically underserved communities (as defined in section 799B) to improve access to health services.

"(d) FUNDING.—For the purpose of carrying out the duties and responsibilities of the Commissioned Corps under this section, there are authorized to be appropriated $5,000,000 for each of fiscal years 2010 through 2014 for recruitment and training and $12,500,000 for each of fiscal years 2010 through 2014 for the Ready Reserve Corps.".

Subtitle D—Enhancing Health Care Workforce Education and Training

SEC. 5301. TRAINING IN FAMILY MEDICINE, GENERAL INTERNAL MEDICINE, GENERAL PEDIATRICS, AND PHYSICIAN ASSISTANTSHIP.

Part C of title VII (42 U.S.C. 293k et seq.) is amended by striking section 747 and inserting the following:

1 **"SEC. 747. PRIMARY CARE TRAINING AND ENHANCEMENT.**

2 "(a) SUPPORT AND DEVELOPMENT OF PRIMARY
3 CARE TRAINING PROGRAMS.—

4 "(1) IN GENERAL.—The Secretary may make
5 grants to, or enter into contracts with, an accredited
6 public or nonprofit private hospital, school of medi-
7 cine or osteopathic medicine, academically affiliated
8 physician assistant training program, or a public or
9 private nonprofit entity which the Secretary has de-
10 termined is capable of carrying out such grant or
11 contract—

12 "(A) to plan, develop, operate, or partici-
13 pate in an accredited professional training pro-
14 gram, including an accredited residency or in-
15 ternship program in the field of family medi-
16 cine, general internal medicine, or general pedi-
17 atrics for medical students, interns, residents,
18 or practicing physicians as defined by the Sec-
19 retary;

20 "(B) to provide need-based financial assist-
21 ance in the form of traineeships and fellowships
22 to medical students, interns, residents, prac-
23 ticing physicians, or other medical personnel,
24 who are participants in any such program, and
25 who plan to specialize or work in the practice
26 of the fields defined in subparagraph (A);

1 "(C) to plan, develop, and operate a pro-
2 gram for the training of physicians who plan to
3 teach in family medicine, general internal medi-
4 cine, or general pediatrics training programs;
5 "(D) to plan, develop, and operate a pro-
6 gram for the training of physicians teaching in
7 community-based settings;
8 "(E) to provide financial assistance in the
9 form of traineeships and fellowships to physi-
10 cians who are participants in any such pro-
11 grams and who plan to teach or conduct re-
12 search in a family medicine, general internal
13 medicine, or general pediatrics training pro-
14 gram;
15 "(F) to plan, develop, and operate a physi-
16 cian assistant education program, and for the
17 training of individuals who will teach in pro-
18 grams to provide such training;
19 "(G) to plan, develop, and operate a dem-
20 onstration program that provides training in
21 new competencies, as recommended by the Ad-
22 visory Committee on Training in Primary Care
23 Medicine and Dentistry and the National
24 Health Care Workforce Commission established

in section 5101 of the Patient Protection and Affordable Care Act, which may include—

"(i) providing training to primary care physicians relevant to providing care through patient-centered medical homes (as defined by the Secretary for purposes of this section);

"(ii) developing tools and curricula relevant to patient-centered medical homes; and

"(iii) providing continuing education to primary care physicians relevant to patient-centered medical homes; and

"(H) to plan, develop, and operate joint degree programs to provide interdisciplinary and interprofessional graduate training in public health and other health professions to provide training in environmental health, infectious disease control, disease prevention and health promotion, epidemiological studies and injury control.

"(2) DURATION OF AWARDS.—The period during which payments are made to an entity from an award of a grant or contract under this subsection shall be 5 years.

1 "(b) CAPACITY BUILDING IN PRIMARY CARE.—

2 "(1) IN GENERAL.—The Secretary may make
3 grants to or enter into contracts with accredited
4 schools of medicine or osteopathic medicine to estab-
5 lish, maintain, or improve—

6 "(A) academic units or programs that im-
7 prove clinical teaching and research in fields de-
8 fined in subsection (a)(1)(A); or

9 "(B) programs that integrate academic ad-
10 ministrative units in fields defined in subsection
11 (a)(1)(A) to enhance interdisciplinary recruit-
12 ment, training, and faculty development.

13 "(2) PREFERENCE IN MAKING AWARDS UNDER
14 THIS SUBSECTION.—In making awards of grants
15 and contracts under paragraph (1), the Secretary
16 shall give preference to any qualified applicant for
17 such an award that agrees to expend the award for
18 the purpose of—

19 "(A) establishing academic units or pro-
20 grams in fields defined in subsection (a)(1)(A);
21 or

22 "(B) substantially expanding such units or
23 programs.

24 "(3) PRIORITIES IN MAKING AWARDS.—In
25 awarding grants or contracts under paragraph (1),

1 the Secretary shall give priority to qualified appli-
2 cants that—
3 "(A) proposes a collaborative project be-
4 tween academic administrative units of primary
5 care;
6 "(B) proposes innovative approaches to
7 clinical teaching using models of primary care,
8 such as the patient centered medical home,
9 team management of chronic disease, and inter-
10 professional integrated models of health care
11 that incorporate transitions in health care set-
12 tings and integration physical and mental
13 health provision;
14 "(C) have a record of training the greatest
15 percentage of providers, or that have dem-
16 onstrated significant improvements in the per-
17 centage of providers trained, who enter and re-
18 main in primary care practice;
19 "(D) have a record of training individuals
20 who are from underrepresented minority groups
21 or from a rural or disadvantaged background;
22 "(E) provide training in the care of vulner-
23 able populations such as children, older adults,
24 homeless individuals, victims of abuse or trau-
25 ma, individuals with mental health or sub-

1 stance-related disorders, individuals with HIV/
2 AIDS, and individuals with disabilities;
3 "(F) establish formal relationships and
4 submit joint applications with federally qualified
5 health centers, rural health clinics, area health
6 education centers, or clinics located in under-
7 served areas or that serve underserved popu-
8 lations;
9 "(G) teach trainees the skills to provide
10 interprofessional, integrated care through col-
11 laboration among health professionals;
12 "(H) provide training in enhanced commu-
13 nication with patients, evidence-based practice,
14 chronic disease management, preventive care,
15 health information technology, or other com-
16 petencies as recommended by the Advisory
17 Committee on Training in Primary Care Medi-
18 cine and Dentistry and the National Health
19 Care Workforce Commission established in sec-
20 tion 5101 of the Patient Protection and Afford-
21 able Care Act; or
22 "(I) provide training in cultural com-
23 petency and health literacy.
24 "(4) DURATION OF AWARDS.—The period dur-
25 ing which payments are made to an entity from an

1 award of a grant or contract under this subsection
2 shall be 5 years.
3 "(c) AUTHORIZATION OF APPROPRIATIONS.—
4 "(1) IN GENERAL.—For purposes of carrying
5 out this section (other than subsection (b)(1)(B)),
6 there are authorized to be appropriated
7 $125,000,000 for fiscal year 2010, and such sums
8 as may be necessary for each of fiscal years 2011
9 through 2014.
10 "(2) TRAINING PROGRAMS.—Fifteen percent of
11 the amount appropriated pursuant to paragraph (1)
12 in each such fiscal year shall be allocated to the phy-
13 sician assistant training programs described in sub-
14 section (a)(1)(F), which prepare students for prac-
15 tice in primary care.
16 "(3) INTEGRATING ACADEMIC ADMINISTRATIVE
17 UNITS.—For purposes of carrying out subsection
18 (b)(1)(B), there are authorized to be appropriated
19 $750,000 for each of fiscal years 2010 through
20 2014.".

21 **SEC. 5302. TRAINING OPPORTUNITIES FOR DIRECT CARE**
22 **WORKERS.**

23 Part C of title VII of the Public Health Service Act
24 (42 U.S.C. 293k et seq.) is amended by inserting after
25 section 747, as amended by section 5301, the following:

"SEC. 747A. TRAINING OPPORTUNITIES FOR DIRECT CARE WORKERS.

"(a) IN GENERAL.—The Secretary shall award grants to eligible entities to enable such entities to provide new training opportunities for direct care workers who are employed in long-term care settings such as nursing homes (as defined in section 1908(e)(1) of the Social Security Act (42 U.S.C. 1396g(e)(1)), assisted living facilities and skilled nursing facilities, intermediate care facilities for individuals with mental retardation, home and community based settings, and any other setting the Secretary determines to be appropriate.

"(b) ELIGIBILITY.—To be eligible to receive a grant under this section, an entity shall—

"(1) be an institution of higher education (as defined in section 102 of the Higher Education Act of 1965 (20 U.S.C. 1002)) that—

"(A) is accredited by a nationally recognized accrediting agency or association listed under section 101(c) of the Higher Education Act of 1965 (20 U.S.C. 1001(c)); and

"(B) has established a public-private educational partnership with a nursing home or skilled nursing facility, agency or entity providing home and community based services to

individuals with disabilities, or other long-term care provider; and

"(2) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

"(c) USE OF FUNDS.—An eligible entity shall use amounts awarded under a grant under this section to provide assistance to eligible individuals to offset the cost of tuition and required fees for enrollment in academic programs provided by such entity.

"(d) ELIGIBLE INDIVIDUAL.—

"(1) ELIGIBILITY.—To be eligible for assistance under this section, an individual shall be enrolled in courses provided by a grantee under this subsection and maintain satisfactory academic progress in such courses.

"(2) CONDITION OF ASSISTANCE.—As a condition of receiving assistance under this section, an individual shall agree that, following completion of the assistance period, the individual will work in the field of geriatrics, disability services, long term services and supports, or chronic care management for a minimum of 2 years under guidelines set by the Secretary.

"(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $10,000,000 for the period of fiscal years 2011 through 2013.".

SEC. 5303. TRAINING IN GENERAL, PEDIATRIC, AND PUBLIC HEALTH DENTISTRY.

Part C of Title VII of the Public Health Service Act (42 U.S.C. 293k et seq.) is amended by—

(1) redesignating section 748, as amended by section 5103 of this Act, as section 749; and

(2) inserting after section 747A, as added by section 5302, the following:

"SEC. 748. TRAINING IN GENERAL, PEDIATRIC, AND PUBLIC HEALTH DENTISTRY.

"(a) SUPPORT AND DEVELOPMENT OF DENTAL TRAINING PROGRAMS.—

"(1) IN GENERAL.—The Secretary may make grants to, or enter into contracts with, a school of dentistry, public or nonprofit private hospital, or a public or private nonprofit entity which the Secretary has determined is capable of carrying out such grant or contract—

"(A) to plan, develop, and operate, or participate in, an approved professional training program in the field of general dentistry, pedi-

atric dentistry, or public health dentistry for dental students, residents, practicing dentists, dental hygienists, or other approved primary care dental trainees, that emphasizes training for general, pediatric, or public health dentistry;

''(B) to provide financial assistance to dental students, residents, practicing dentists, and dental hygiene students who are in need thereof, who are participants in any such program, and who plan to work in the practice of general, pediatric, public heath dentistry, or dental hygiene;

''(C) to plan, develop, and operate a program for the training of oral health care providers who plan to teach in general, pediatric, public health dentistry, or dental hygiene;

''(D) to provide financial assistance in the form of traineeships and fellowships to dentists who plan to teach or are teaching in general, pediatric, or public health dentistry;

''(E) to meet the costs of projects to establish, maintain, or improve dental faculty development programs in primary care (which may be departments, divisions or other units);

"(F) to meet the costs of projects to establish, maintain, or improve predoctoral and postdoctoral training in primary care programs;

"(G) to create a loan repayment program for faculty in dental programs; and

"(H) to provide technical assistance to pediatric training programs in developing and implementing instruction regarding the oral health status, dental care needs, and risk-based clinical disease management of all pediatric populations with an emphasis on underserved children.

"(2) FACULTY LOAN REPAYMENT.—

"(A) IN GENERAL.—A grant or contract under subsection (a)(1)(G) may be awarded to a program of general, pediatric, or public health dentistry described in such subsection to plan, develop, and operate a loan repayment program under which—

"(i) individuals agree to serve full-time as faculty members; and

"(ii) the program of general, pediatric or public health dentistry agrees to pay the principal and interest on the outstanding student loans of the individuals.

"(B) MANNER OF PAYMENTS.—With respect to the payments described in subparagraph (A)(ii), upon completion by an individual of each of the first, second, third, fourth, and fifth years of service, the program shall pay an amount equal to 10, 15, 20, 25, and 30 percent, respectively, of the individual's student loan balance as calculated based on principal and interest owed at the initiation of the agreement.

"(b) ELIGIBLE ENTITY.—For purposes of this subsection, entities eligible for such grants or contracts in general, pediatric, or public health dentistry shall include entities that have programs in dental or dental hygiene schools, or approved residency or advanced education programs in the practice of general, pediatric, or public health dentistry. Eligible entities may partner with schools of public health to permit the education of dental students, residents, and dental hygiene students for a master's year in public health at a school of public health.

"(c) PRIORITIES IN MAKING AWARDS.—With respect to training provided for under this section, the Secretary shall give priority in awarding grants or contracts to the following:

1 ''(1) Qualified applicants that propose collabo-
2 rative projects between departments of primary care
3 medicine and departments of general, pediatric, or
4 public health dentistry.

5 ''(2) Qualified applicants that have a record of
6 training the greatest percentage of providers, or that
7 have demonstrated significant improvements in the
8 percentage of providers, who enter and remain in
9 general, pediatric, or public health dentistry.

10 ''(3) Qualified applicants that have a record of
11 training individuals who are from a rural or dis-
12 advantaged background, or from underrepresented
13 minorities.

14 ''(4) Qualified applicants that establish formal
15 relationships with Federally qualified health centers,
16 rural health centers, or accredited teaching facilities
17 and that conduct training of students, residents, fel-
18 lows, or faculty at the center or facility.

19 ''(5) Qualified applicants that conduct teaching
20 programs targeting vulnerable populations such as
21 older adults, homeless individuals, victims of abuse
22 or trauma, individuals with mental health or sub-
23 stance-related disorders, individuals with disabilities,
24 and individuals with HIV/AIDS, and in the risk-
25 based clinical disease management of all populations.

1 "(6) Qualified applicants that include edu-
2 cational activities in cultural competency and health
3 literacy.
4 "(7) Qualified applicants that have a high rate
5 for placing graduates in practice settings that serve
6 underserved areas or health disparity populations, or
7 who achieve a significant increase in the rate of
8 placing graduates in such settings.
9 "(8) Qualified applicants that intend to estab-
10 lish a special populations oral health care education
11 center or training program for the didactic and clin-
12 ical education of dentists, dental health profes-
13 sionals, and dental hygienists who plan to teach oral
14 health care for people with developmental disabil-
15 ities, cognitive impairment, complex medical prob-
16 lems, significant physical limitations, and vulnerable
17 elderly.
18 "(d) APPLICATION.—An eligible entity desiring a
19 grant under this section shall submit to the Secretary an
20 application at such time, in such manner, and containing
21 such information as the Secretary may require.
22 "(e) DURATION OF AWARD.—The period during
23 which payments are made to an entity from an award of
24 a grant or contract under subsection (a) shall be 5 years.
25 The provision of such payments shall be subject to annual

1 approval by the Secretary and subject to the availability
2 of appropriations for the fiscal year involved to make the
3 payments.

4 "(f) AUTHORIZATIONS OF APPROPRIATIONS.—For
5 the purpose of carrying out subsections (a) and (b), there
6 is authorized to be appropriated $30,000,000 for fiscal
7 year 2010 and such sums as may be necessary for each
8 of fiscal years 2011 through 2015.

9 "(g) CARRYOVER FUNDS.—An entity that receives an
10 award under this section may carry over funds from 1 fis-
11 cal year to another without obtaining approval from the
12 Secretary. In no case may any funds be carried over pur-
13 suant to the preceding sentence for more than 3 years.".

14 **SEC. 5304. ALTERNATIVE DENTAL HEALTH CARE PRO-**
15 **VIDERS DEMONSTRATION PROJECT.**

16 Subpart X of part D of title III of the Public Health
17 Service Act (42 U.S.C. 256f et seq.) is amended by adding
18 at the end the following:

19 **"SEC. 340G–1. DEMONSTRATION PROGRAM.**

20 "(a) IN GENERAL.—

21 "(1) AUTHORIZATION.—The Secretary is au-
22 thorized to award grants to 15 eligible entities to en-
23 able such entities to establish a demonstration pro-
24 gram to establish training programs to train, or to
25 employ, alternative dental health care providers in

order to increase access to dental health care services in rural and other underserved communities.

"(2) DEFINITION.—The term 'alternative dental health care providers' includes community dental health coordinators, advance practice dental hygienists, independent dental hygienists, supervised dental hygienists, primary care physicians, dental therapists, dental health aides, and any other health professional that the Secretary determines appropriate.

"(b) TIMEFRAME.—The demonstration projects funded under this section shall begin not later than 2 years after the date of enactment of this section, and shall conclude not later than 7 years after such date of enactment.

"(c) ELIGIBLE ENTITIES.—To be eligible to receive a grant under subsection (a), an entity shall—

"(1) be—

"(A) an institution of higher education, including a community college;

"(B) a public-private partnership;

"(C) a federally qualified health center;

"(D) an Indian Health Service facility or a tribe or tribal organization (as such terms are defined in section 4 of the Indian Self-Determination and Education Assistance Act);

1 "(E) a State or county public health clinic,
2 a health facility operated by an Indian tribe or
3 tribal organization, or urban Indian organiza-
4 tion providing dental services; or
5 "(F) a public hospital or health system;
6 "(2) be within a program accredited by the
7 Commission on Dental Accreditation or within a
8 dental education program in an accredited institu-
9 tion; and
10 "(3) shall submit an application to the Sec-
11 retary at such time, in such manner, and containing
12 such information as the Secretary may require.
13 "(d) ADMINISTRATIVE PROVISIONS.—
14 "(1) AMOUNT OF GRANT.—Each grant under
15 this section shall be in an amount that is not less
16 than $4,000,000 for the 5-year period during which
17 the demonstration project being conducted.
18 "(2) DISBURSEMENT OF FUNDS.—
19 "(A) PRELIMINARY DISBURSEMENTS.—Be-
20 ginning 1 year after the enactment of this sec-
21 tion, the Secretary may disperse to any entity
22 receiving a grant under this section not more
23 than 20 percent of the total funding awarded to
24 such entity under such grant, for the purpose

of enabling the entity to plan the demonstration project to be conducted under such grant.

"(B) SUBSEQUENT DISBURSEMENTS.—The remaining amount of grant funds not dispersed under subparagraph (A) shall be dispersed such that not less than 15 percent of such remaining amount is dispersed each subsequent year.

"(e) COMPLIANCE WITH STATE REQUIREMENTS.—Each entity receiving a grant under this section shall certify that it is in compliance with all applicable State licensing requirements.

"(f) EVALUATION.—The Secretary shall contract with the Director of the Institute of Medicine to conduct a study of the demonstration programs conducted under this section that shall provide analysis, based upon quantitative and qualitative data, regarding access to dental health care in the United States.

"(g) CLARIFICATION REGARDING DENTAL HEALTH AIDE PROGRAM.—Nothing in this section shall prohibit a dental health aide training program approved by the Indian Health Service from being eligible for a grant under this section.

"(h) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated such sums as may be necessary to carry out this section.".

SEC. 5305. GERIATRIC EDUCATION AND TRAINING; CAREER AWARDS; COMPREHENSIVE GERIATRIC EDUCATION.

(a) WORKFORCE DEVELOPMENT; CAREER AWARDS.—Section 753 of the Public Health Service Act (42 U.S.C. 294c) is amended by adding at the end the following:

"(d) GERIATRIC WORKFORCE DEVELOPMENT.—

"(1) IN GENERAL.—The Secretary shall award grants or contracts under this subsection to entities that operate a geriatric education center pursuant to subsection (a)(1).

"(2) APPLICATION.—To be eligible for an award under paragraph (1), an entity described in such paragraph shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

"(3) USE OF FUNDS.—Amounts awarded under a grant or contract under paragraph (1) shall be used to—

"(A) carry out the fellowship program described in paragraph (4); and

"(B) carry out 1 of the 2 activities described in paragraph (5).

"(4) FELLOWSHIP PROGRAM.—

1 "(A) IN GENERAL.—Pursuant to para-
2 graph (3), a geriatric education center that re-
3 ceives an award under this subsection shall use
4 such funds to offer short-term intensive courses
5 (referred to in this subsection as a 'fellowship')
6 that focus on geriatrics, chronic care manage-
7 ment, and long-term care that provide supple-
8 mental training for faculty members in medical
9 schools and other health professions schools
10 with programs in psychology, pharmacy, nurs-
11 ing, social work, dentistry, public health, allied
12 health, or other health disciplines, as approved
13 by the Secretary. Such a fellowship shall be
14 open to current faculty, and appropriately
15 credentialed volunteer faculty and practitioners,
16 who do not have formal training in geriatrics,
17 to upgrade their knowledge and clinical skills
18 for the care of older adults and adults with
19 functional limitations and to enhance their
20 interdisciplinary teaching skills.
21 "(B) LOCATION.—A fellowship shall be of-
22 fered either at the geriatric education center
23 that is sponsoring the course, in collaboration
24 with other geriatric education centers, or at
25 medical schools, schools of dentistry, schools of

1 nursing, schools of pharmacy, schools of social
2 work, graduate programs in psychology, or al-
3 lied health and other health professions schools
4 approved by the Secretary with which the geri-
5 atric education centers are affiliated.

6 "(C) CME CREDIT.—Participation in a fel-
7 lowship under this paragraph shall be accepted
8 with respect to complying with continuing
9 health profession education requirements. As a
10 condition of such acceptance, the recipient shall
11 agree to subsequently provide a minimum of 18
12 hours of voluntary instructional support
13 through a geriatric education center that is pro-
14 viding clinical training to students or trainees
15 in long-term care settings.

16 "(5) ADDITIONAL REQUIRED ACTIVITIES DE-
17 SCRIBED.—Pursuant to paragraph (3), a geriatric
18 education center that receives an award under this
19 subsection shall use such funds to carry out 1 of the
20 following 2 activities.

21 "(A) FAMILY CAREGIVER AND DIRECT
22 CARE PROVIDER TRAINING.—A geriatric edu-
23 cation center that receives an award under this
24 subsection shall offer at least 2 courses each
25 year, at no charge or nominal cost, to family

1 caregivers and direct care providers that are de-
2 signed to provide practical training for sup-
3 porting frail elders and individuals with disabil-
4 ities. The Secretary shall require such Centers
5 to work with appropriate community partners
6 to develop training program content and to
7 publicize the availability of training courses in
8 their service areas. All family caregiver and di-
9 rect care provider training programs shall in-
10 clude instruction on the management of psycho-
11 logical and behavioral aspects of dementia, com-
12 munication techniques for working with individ-
13 uals who have dementia, and the appropriate,
14 safe, and effective use of medications for older
15 adults.

16 "(B) INCORPORATION OF BEST PRAC-
17 TICES.—A geriatric education center that re-
18 ceives an award under this subsection shall de-
19 velop and include material on depression and
20 other mental disorders common among older
21 adults, medication safety issues for older adults,
22 and management of the psychological and be-
23 havioral aspects of dementia and communica-
24 tion techniques with individuals who have de-

mentia in all training courses, where appropriate.

"(6) TARGETS.—A geriatric education center that receives an award under this subsection shall meet targets approved by the Secretary for providing geriatric training to a certain number of faculty or practitioners during the term of the award, as well as other parameters established by the Secretary.

"(7) AMOUNT OF AWARD.—An award under this subsection shall be in an amount of $150,000. Not more than 24 geriatric education centers may receive an award under this subsection.

"(8) MAINTENANCE OF EFFORT.—A geriatric education center that receives an award under this subsection shall provide assurances to the Secretary that funds provided to the geriatric education center under this subsection will be used only to supplement, not to supplant, the amount of Federal, State, and local funds otherwise expended by the geriatric education center.

"(9) AUTHORIZATION OF APPROPRIATIONS.—In addition to any other funding available to carry out this section, there is authorized to be appropriated to carry out this subsection, $10,800,000 for the period of fiscal year 2011 through 2014.

1 "(e) GERIATRIC CAREER INCENTIVE AWARDS.—

2 "(1) IN GENERAL.—The Secretary shall award
3 grants or contracts under this section to individuals
4 described in paragraph (2) to foster greater interest
5 among a variety of health professionals in entering
6 the field of geriatrics, long-term care, and chronic
7 care management.

8 "(2) ELIGIBLE INDIVIDUALS.—To be eligible to
9 received an award under paragraph (1), an indi-
10 vidual shall—

11 "(A) be an advanced practice nurse, a clin-
12 ical social worker, a pharmacist, or student of
13 psychology who is pursuing a doctorate or other
14 advanced degree in geriatrics or related fields in
15 an accredited health professions school; and

16 "(B) submit to the Secretary an applica-
17 tion at such time, in such manner, and con-
18 taining such information as the Secretary may
19 require.

20 "(3) CONDITION OF AWARD.—As a condition of
21 receiving an award under this subsection, an indi-
22 vidual shall agree that, following completion of the
23 award period, the individual will teach or practice in
24 the field of geriatrics, long-term care, or chronic

1 care management for a minimum of 5 years under
2 guidelines set by the Secretary.
3 "(4) AUTHORIZATION OF APPROPRIATIONS.—
4 There is authorized to be appropriated to carry out
5 this subsection, $10,000,000 for the period of fiscal
6 years 2011 through 2013.".
7 (b) EXPANSION OF ELIGIBILITY FOR GERIATRIC
8 ACADEMIC CAREER AWARDS; PAYMENT TO INSTITU-
9 TION.—Section 753(c) of the Public Health Service Act
10 294(c)) is amended—
11 (1) by redesignating paragraphs (4) and (5) as
12 paragraphs (5) and (6), respectively;
13 (2) by striking paragraph (2) through para-
14 graph (3) and inserting the following:
15 "(2) ELIGIBLE INDIVIDUALS.—To be eligible to
16 receive an Award under paragraph (1), an individual
17 shall—
18 "(A) be board certified or board eligible in
19 internal medicine, family practice, psychiatry,
20 or licensed dentistry, or have completed any re-
21 quired training in a discipline and employed in
22 an accredited health professions school that is
23 approved by the Secretary;
24 "(B) have completed an approved fellow-
25 ship program in geriatrics or have completed

specialty training in geriatrics as required by the discipline and any addition geriatrics training as required by the Secretary; and

"(C) have a junior (non-tenured) faculty appointment at an accredited (as determined by the Secretary) school of medicine, osteopathic medicine, nursing, social work, psychology, dentistry, pharmacy, or other allied health disciplines in an accredited health professions school that is approved by the Secretary.

"(3) LIMITATIONS.—No Award under paragraph (1) may be made to an eligible individual unless the individual—

"(A) has submitted to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require, and the Secretary has approved such application;

"(B) provides, in such form and manner as the Secretary may require, assurances that the individual will meet the service requirement described in paragraph (6); and

"(C) provides, in such form and manner as the Secretary may require, assurances that the individual has a full-time faculty appointment

in a health professions institution and documented commitment from such institution to spend 75 percent of the total time of such individual on teaching and developing skills in interdisciplinary education in geriatrics.

''(4) MAINTENANCE OF EFFORT.—An eligible individual that receives an Award under paragraph (1) shall provide assurances to the Secretary that funds provided to the eligible individual under this subsection will be used only to supplement, not to supplant, the amount of Federal, State, and local funds otherwise expended by the eligible individual.''; and

(3) in paragraph (5), as so designated—

(A) in subparagraph (A)—

(i) by inserting ''for individuals who are physicians'' after ''this section''; and

(ii) by inserting after the period at the end the following: ''The Secretary shall determine the amount of an Award under this section for individuals who are not physicians.''; and

(B) by adding at the end the following:

''(C) PAYMENT TO INSTITUTION.—The Secretary shall make payments to institutions

which include schools of medicine, osteopathic medicine, nursing, social work, psychology, dentistry, and pharmacy, or other allied health discipline in an accredited health professions school that is approved by the Secretary.''.

(c) COMPREHENSIVE GERIATRIC EDUCATION.—Section 855 of the Public Health Service Act (42 U.S.C. 298) is amended—

(1) in subsection (b)—

(A) in paragraph (3), by striking ''or'' at the end;

(B) in paragraph (4), by striking the period and inserting ''; or''; and

(C) by adding at the end the following:

''(5) establish traineeships for individuals who are preparing for advanced education nursing degrees in geriatric nursing, long-term care, gero-psychiatric nursing or other nursing areas that specialize in the care of the elderly population.''; and

(2) in subsection (e), by striking ''2003 through 2007'' and inserting ''2010 through 2014''.

SEC. 5306. MENTAL AND BEHAVIORAL HEALTH EDUCATION AND TRAINING GRANTS.

(a) IN GENERAL.—Part D of title VII (42 U.S.C. 294 et seq.) is amended by—

(1) striking section 757;

(2) redesignating section 756 (as amended by section 5103) as section 757; and

(3) inserting after section 755 the following:

"SEC. 756. MENTAL AND BEHAVIORAL HEALTH EDUCATION AND TRAINING GRANTS.

''(a) GRANTS AUTHORIZED.—The Secretary may award grants to eligible institutions of higher education to support the recruitment of students for, and education and clinical experience of the students in—

''(1) baccalaureate, master's, and doctoral degree programs of social work, as well as the development of faculty in social work;

''(2) accredited master's, doctoral, internship, and post-doctoral residency programs of psychology for the development and implementation of interdisciplinary training of psychology graduate students for providing behavioral and mental health services, including substance abuse prevention and treatment services;

''(3) accredited institutions of higher education or accredited professional training programs that are establishing or expanding internships or other field placement programs in child and adolescent mental health in psychiatry, psychology, school psychology,

behavioral pediatrics, psychiatric nursing, social work, school social work, substance abuse prevention and treatment, marriage and family therapy, school counseling, or professional counseling; and

''(4) State-licensed mental health nonprofit and for-profit organizations to enable such organizations to pay for programs for preservice or in-service training of paraprofessional child and adolescent mental health workers.

''(b) ELIGIBILITY REQUIREMENTS.—To be eligible for a grant under this section, an institution shall demonstrate—

''(1) participation in the institutions' programs of individuals and groups from different racial, ethnic, cultural, geographic, religious, linguistic, and class backgrounds, and different genders and sexual orientations;

''(2) knowledge and understanding of the concerns of the individuals and groups described in subsection (a);

''(3) any internship or other field placement program assisted under the grant will prioritize cultural and linguistic competency;

"(4) the institution will provide to the Secretary such data, assurances, and information as the Secretary may require; and

"(5) with respect to any violation of the agreement between the Secretary and the institution, the institution will pay such liquidated damages as prescribed by the Secretary by regulation.

"(c) INSTITUTIONAL REQUIREMENT.—For grants authorized under subsection (a)(1), at least 4 of the grant recipients shall be historically black colleges or universities or other minority-serving institutions.

"(d) PRIORITY.—

"(1) In selecting the grant recipients in social work under subsection (a)(1), the Secretary shall give priority to applicants that—

"(A) are accredited by the Council on Social Work Education;

"(B) have a graduation rate of not less than 80 percent for social work students; and

"(C) exhibit an ability to recruit social workers from and place social workers in areas with a high need and high demand population.

"(2) In selecting the grant recipients in graduate psychology under subsection (a)(2), the Secretary shall give priority to institutions in which

training focuses on the needs of vulnerable groups such as older adults and children, individuals with mental health or substance-related disorders, victims of abuse or trauma and of combat stress disorders such as posttraumatic stress disorder and traumatic brain injuries, homeless individuals, chronically ill persons, and their families.

"(3) In selecting the grant recipients in training programs in child and adolescent mental health under subsections (a)(3) and (a)(4), the Secretary shall give priority to applicants that—

"(A) have demonstrated the ability to collect data on the number of students trained in child and adolescent mental health and the populations served by such students after graduation or completion of preservice or in-service training;

"(B) have demonstrated familiarity with evidence-based methods in child and adolescent mental health services, including substance abuse prevention and treatment services;

"(C) have programs designed to increase the number of professionals and paraprofessionals serving high-priority populations and to applicants who come from high-priority commu-

nities and plan to serve medically underserved populations, in health professional shortage areas, or in medically underserved areas;

"(D) offer curriculum taught collaboratively with a family on the consumer and family lived experience or the importance of family-professional or family-paraprofessional partnerships; and

"(E) provide services through a community mental health program described in section 1913(b)(1).

"(e) AUTHORIZATION OF APPROPRIATION.—For the fiscal years 2010 through 2013, there is authorized to be appropriated to carry out this section—

"(1) $8,000,000 for training in social work in subsection (a)(1);

"(2) $12,000,000 for training in graduate psychology in subsection (a)(2), of which not less than $10,000,000 shall be allocated for doctoral, postdoctoral, and internship level training;

"(3) $10,000,000 for training in professional child and adolescent mental health in subsection (a)(3); and

"(4) $5,000,000 for training in paraprofessional child and adolescent work in subsection (a)(4).".

(b) CONFORMING AMENDMENTS.—Section 757(b)(2) of the Public Health Service Act, as redesignated by subsection (a), is amended by striking "sections 751(a)(1)(A), 751(a)(1)(B), 753(b), 754(3)(A), and 755(b)" and inserting "sections 751(b)(1)(A), 753(b), and 755(b)".

SEC. 5307. CULTURAL COMPETENCY, PREVENTION, AND PUBLIC HEALTH AND INDIVIDUALS WITH DISABILITIES TRAINING.

(a) TITLE VII.—Section 741 of the Public Health Service Act (42 U.S.C. 293e) is amended—

(1) in subsection (a)—

(A) by striking the subsection heading and inserting "CULTURAL COMPETENCY, PREVENTION, AND PUBLIC HEALTH AND INDIVIDUALS WITH DISABILITY GRANTS"; and

(B) in paragraph (1), by striking "for the purpose of" and all that follows through the period at the end and inserting "for the development, evaluation, and dissemination of research, demonstration projects, and model curricula for cultural competency, prevention, public health proficiency, reducing health disparities, and ap-

titude for working with individuals with disabilities training for use in health professions schools and continuing education programs, and for other purposes determined as appropriate by the Secretary.''; and

(2) by striking subsection (b) and inserting the following:

''(b) COLLABORATION.—In carrying out subsection (a), the Secretary shall collaborate with health professional societies, licensing and accreditation entities, health professions schools, and experts in minority health and cultural competency, prevention, and public health and disability groups, community-based organizations, and other organizations as determined appropriate by the Secretary. The Secretary shall coordinate with curricula and research and demonstration projects developed under section 807.

''(c) DISSEMINATION.—

''(1) IN GENERAL.—Model curricula developed under this section shall be disseminated through the Internet Clearinghouse under section 270 and such other means as determined appropriate by the Secretary.

''(2) EVALUATION.—The Secretary shall evaluate the adoption and the implementation of cultural

1 competency, prevention, and public health, and
2 working with individuals with a disability training
3 curricula, and the facilitate inclusion of these com-
4 petency measures in quality measurement systems as
5 appropriate.

6 ''(d) AUTHORIZATION OF APPROPRIATIONS.—There
7 is authorized to be appropriated to carry out this section
8 such sums as may be necessary for each of fiscal years
9 2010 through 2015.''.

10 (b) TITLE VIII.—Section 807 of the Public Health
11 Service Act (42 U.S.C. 296e–1) is amended—

12 (1) in subsection (a)—

13 (A) by striking the subsection heading and
14 inserting ''CULTURAL COMPETENCY, PREVEN-
15 TION, AND PUBLIC HEALTH AND INDIVIDUALS
16 WITH DISABILITY GRANTS''; and

17 (B) by striking ''for the purpose of'' and
18 all that follows through ''health care.'' and in-
19 serting ''for the development, evaluation, and
20 dissemination of research, demonstration
21 projects, and model curricula for cultural com-
22 petency, prevention, public health proficiency,
23 reducing health disparities, and aptitude for
24 working with individuals with disabilities train-
25 ing for use in health professions schools and

continuing education programs, and for other purposes determined as appropriate by the Secretary.''; and

(2) by redesignating subsection (b) as subsection (d);

(3) by inserting after subsection (a) the following:

''(b) COLLABORATION.—In carrying out subsection (a), the Secretary shall collaborate with the entities described in section 741(b). The Secretary shall coordinate with curricula and research and demonstration projects developed under such section 741.

''(c) DISSEMINATION.—Model curricula developed under this section shall be disseminated and evaluated in the same manner as model curricula developed under section 741, as described in subsection (c) of such section.''; and

(4) in subsection (d), as so redesignated—

(A) by striking ''subsection (a)'' and inserting ''this section''; and

(B) by striking ''2001 through 2004'' and inserting ''2010 through 2015''.

SEC. 5308. ADVANCED NURSING EDUCATION GRANTS.

Section 811 of the Public Health Service Act (42 U.S.C. 296j) is amended—

(1) in subsection (c)—

(A) in the subsection heading, by striking "AND NURSE MIDWIFERY PROGRAMS"; and

(B) by striking "and nurse midwifery";

(2) in subsection (f)—

(A) by striking paragraph (2); and

(B) by redesignating paragraph (3) as paragraph (2); and

(3) by redesignating subsections (d), (e), and (f) as subsections (e), (f), and (g), respectively; and

(4) by inserting after subsection (c), the following:

"(d) AUTHORIZED NURSE-MIDWIFERY PROGRAMS.—Midwifery programs that are eligible for support under this section are educational programs that—

"(1) have as their objective the education of midwives; and

"(2) are accredited by the American College of Nurse-Midwives Accreditation Commission for Midwifery Education.".

SEC. 5309. NURSE EDUCATION, PRACTICE, AND RETENTION GRANTS.

(a) IN GENERAL.—Section 831 of the Public Health Service Act (42 U.S.C. 296p) is amended—

(1) in the section heading, by striking "**RETENTION**" and inserting "**QUALITY**";

(2) in subsection (a)—

(A) in paragraph (1), by adding "or" after the semicolon;

(B) by striking paragraph (2); and

(C) by redesignating paragraph (3) as paragraph (2);

(3) in subsection (b)(3), by striking "managed care, quality improvement" and inserting "coordinated care";

(4) in subsection (g), by inserting ", as defined in section 801(2)," after "school of nursing"; and

(5) in subsection (h), by striking "2003 through 2007" and inserting "2010 through 2014".

(b) NURSE RETENTION GRANTS.—Title VIII of the Public Health Service Act is amended by inserting after section 831 (42 U.S.C. 296b) the following:

"SEC. 831A. NURSE RETENTION GRANTS.

"(a) RETENTION PRIORITY AREAS.—The Secretary may award grants to, and enter into contracts with, eligible entities to enhance the nursing workforce by initiating and maintaining nurse retention programs pursuant to subsection (b) or (c).

1 "(b) GRANTS FOR CAREER LADDER PROGRAM.—The
2 Secretary may award grants to, and enter into contracts
3 with, eligible entities for programs—
4 "(1) to promote career advancement for individ-
5 uals including licensed practical nurses, licensed vo-
6 cational nurses, certified nurse assistants, home
7 health aides, diploma degree or associate degree
8 nurses, to become baccalaureate prepared registered
9 nurses or advanced education nurses in order to
10 meet the needs of the registered nurse workforce;
11 "(2) developing and implementing internships
12 and residency programs in collaboration with an ac-
13 credited school of nursing, as defined by section
14 801(2), to encourage mentoring and the development
15 of specialties; or
16 "(3) to assist individuals in obtaining education
17 and training required to enter the nursing profession
18 and advance within such profession.
19 "(c) ENHANCING PATIENT CARE DELIVERY SYS-
20 TEMS.—
21 "(1) GRANTS.—The Secretary may award
22 grants to eligible entities to improve the retention of
23 nurses and enhance patient care that is directly re-
24 lated to nursing activities by enhancing collaboration
25 and communication among nurses and other health

1 care professionals, and by promoting nurse involve-
2 ment in the organizational and clinical decision-mak-
3 ing processes of a health care facility.

4 "(2) PRIORITY.—In making awards of grants
5 under this subsection, the Secretary shall give pref-
6 erence to applicants that have not previously re-
7 ceived an award under this subsection (or section
8 831(c) as such section existed on the day before the
9 date of enactment of this section).

10 "(3) CONTINUATION OF AN AWARD.—The Sec-
11 retary shall make continuation of any award under
12 this subsection beyond the second year of such
13 award contingent on the recipient of such award
14 having demonstrated to the Secretary measurable
15 and substantive improvement in nurse retention or
16 patient care.

17 "(d) OTHER PRIORITY AREAS.—The Secretary may
18 award grants to, or enter into contracts with, eligible enti-
19 ties to address other areas that are of high priority to
20 nurse retention, as determined by the Secretary.

21 "(e) REPORT.—The Secretary shall submit to the
22 Congress before the end of each fiscal year a report on
23 the grants awarded and the contracts entered into under
24 this section. Each such report shall identify the overall
25 number of such grants and contracts and provide an ex-

1 planation of why each such grant or contract will meet
2 the priority need of the nursing workforce.

3 "(f) ELIGIBLE ENTITY.—For purposes of this sec-
4 tion, the term 'eligible entity' includes an accredited school
5 of nursing, as defined by section 801(2), a health care fa-
6 cility, or a partnership of such a school and facility.

7 "(g) AUTHORIZATION OF APPROPRIATIONS.—There
8 are authorized to be appropriated to carry out this section
9 such sums as may be necessary for each of fiscal years
10 2010 through 2012.".

11 **SEC. 5310. LOAN REPAYMENT AND SCHOLARSHIP PRO-**
12 **GRAM.**

13 (a) LOAN REPAYMENTS AND SCHOLARSHIPS.—Sec-
14 tion 846(a)(3) of the Public Health Service Act (42 U.S.C.
15 297n(a)(3)) is amended by inserting before the semicolon
16 the following: ", or in a accredited school of nursing, as
17 defined by section 801(2), as nurse faculty".

18 (b) TECHNICAL AND CONFORMING AMENDMENTS.—
19 Title VIII (42 U.S.C. 296 et seq.) is amended—

20 (1) by redesignating section 810 (relating to
21 prohibition against discrimination by schools on the
22 basis of sex) as section 809 and moving such section
23 so that it follows section 808;

(2) in sections 835, 836, 838, 840, and 842, by striking the term ''this subpart'' each place it appears and inserting ''this part'';

(3) in section 836(h), by striking the last sentence;

(4) in section 836, by redesignating subsection (l) as subsection (k);

(5) in section 839, by striking ''839'' and all that follows through ''(a)'' and inserting ''839. (a)'';

(6) in section 835(b), by striking ''841'' each place it appears and inserting ''871'';

(7) by redesignating section 841 as section 871, moving part F to the end of the title, and redesignating such part as part I;

(8) in part G—

(A) by redesignating section 845 as section 851; and

(B) by redesignating part G as part F;

(9) in part H—

(A) by redesignating sections 851 and 852 as sections 861 and 862, respectively; and

(B) by redesignating part H as part G; and

(10) in part I—

(A) by redesignating section 855, as amended by section 5305, as section 865; and

(B) by redesignating part I as part H.

SEC. 5311. NURSE FACULTY LOAN PROGRAM.

(a) IN GENERAL.—Section 846A of the Public Health Service Act (42 U.S.C. 297n–1) is amended—

(1) in subsection (a)—

(A) in the subsection heading, by striking ''ESTABLISHMENT'' and inserting ''SCHOOL OF NURSING STUDENT LOAN FUND''; and

(B) by inserting ''accredited'' after ''agreement with any'';

(2) in subsection (c)—

(A) in paragraph (2), by striking ''$30,000'' and all that follows through the semicolon and inserting ''$35,500, during fiscal years 2010 and 2011 fiscal years (after fiscal year 2011, such amounts shall be adjusted to provide for a cost-of-attendance increase for the yearly loan rate and the aggregate loan;''; and

(B) in paragraph (3)(A), by inserting ''an accredited'' after ''faculty member in'';

(3) in subsection (e), by striking ''a school'' and inserting ''an accredited school''; and

(4) in subsection (f), by striking ''2003 through 2007'' and inserting ''2010 through 2014''.

(b) ELIGIBLE INDIVIDUAL STUDENT LOAN REPAYMENT.—Title VIII of the Public Health Service Act is amended by inserting after section 846A (42 U.S.C. 297n–1) the following:

''SEC. 847. ELIGIBLE INDIVIDUAL STUDENT LOAN REPAYMENT.

''(a) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, may enter into an agreement with eligible individuals for the repayment of education loans, in accordance with this section, to increase the number of qualified nursing faculty.

''(b) AGREEMENTS.—Each agreement entered into under this subsection shall require that the eligible individual shall serve as a full-time member of the faculty of an accredited school of nursing, for a total period, in the aggregate, of at least 4 years during the 6-year period beginning on the later of—

''(1) the date on which the individual receives a master's or doctorate nursing degree from an accredited school of nursing; or

''(2) the date on which the individual enters into an agreement under this subsection.

1 "(c) AGREEMENT PROVISIONS.—Agreements entered
2 into pursuant to subsection (b) shall be entered into on
3 such terms and conditions as the Secretary may deter-
4 mine, except that—
5 "(1) not more than 10 months after the date on
6 which the 6-year period described under subsection
7 (b) begins, but in no case before the individual
8 starts as a full-time member of the faculty of an ac-
9 credited school of nursing the Secretary shall begin
10 making payments, for and on behalf of that indi-
11 vidual, on the outstanding principal of, and interest
12 on, any loan of that individual obtained to pay for
13 such degree;
14 "(2) for an individual who has completed a
15 master's in nursing or equivalent degree in nurs-
16 ing—
17 "(A) payments may not exceed $10,000
18 per calendar year; and
19 "(B) total payments may not exceed
20 $40,000 during the 2010 and 2011 fiscal years
21 (after fiscal year 2011, such amounts shall be
22 adjusted to provide for a cost-of-attendance in-
23 crease for the yearly loan rate and the aggre-
24 gate loan); and

"(3) for an individual who has completed a doctorate or equivalent degree in nursing—

"(A) payments may not exceed $20,000 per calendar year; and

"(B) total payments may not exceed $80,000 during the 2010 and 2011 fiscal years (adjusted for subsequent fiscal years as provided for in the same manner as in paragraph (2)(B)).

"(d) BREACH OF AGREEMENT.—

"(1) IN GENERAL.—In the case of any agreement made under subsection (b), the individual is liable to the Federal Government for the total amount paid by the Secretary under such agreement, and for interest on such amount at the maximum legal prevailing rate, if the individual fails to meet the agreement terms required under such subsection.

"(2) WAIVER OR SUSPENSION OF LIABILITY.—In the case of an individual making an agreement for purposes of paragraph (1), the Secretary shall provide for the waiver or suspension of liability under such paragraph if compliance by the individual with the agreement involved is impossible or would involve extreme hardship to the individual or

if enforcement of the agreement with respect to the individual would be unconscionable.

"(3) DATE CERTAIN FOR RECOVERY.—Subject to paragraph (2), any amount that the Federal Government is entitled to recover under paragraph (1) shall be paid to the United States not later than the expiration of the 3-year period beginning on the date the United States becomes so entitled.

"(4) AVAILABILITY.—Amounts recovered under paragraph (1) shall be available to the Secretary for making loan repayments under this section and shall remain available for such purpose until expended.

"(e) ELIGIBLE INDIVIDUAL DEFINED.—For purposes of this section, the term 'eligible individual' means an individual who—

"(1) is a United States citizen, national, or lawful permanent resident;

"(2) holds an unencumbered license as a registered nurse; and

"(3) has either already completed a master's or doctorate nursing program at an accredited school of nursing or is currently enrolled on a full-time or part-time basis in such a program.

"(f) PRIORITY.—For the purposes of this section and section 846A, funding priority will be awarded to School

of Nursing Student Loans that support doctoral nursing students or Individual Student Loan Repayment that support doctoral nursing students.

"(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2010 through 2014.".

SEC. 5312. AUTHORIZATION OF APPROPRIATIONS FOR PARTS B THROUGH D OF TITLE VIII.

Section 871 of the Public Health Service Act, as redesignated and moved by section 5310, is amended to read as follows:

"SEC. 871. AUTHORIZATION OF APPROPRIATIONS.

"For the purpose of carrying out parts B, C, and D (subject to section 851(g)), there are authorized to be appropriated $338,000,000 for fiscal year 2010, and such sums as may be necessary for each of the fiscal years 2011 through 2016.".

SEC. 5313. GRANTS TO PROMOTE THE COMMUNITY HEALTH WORKFORCE.

(a) IN GENERAL.—Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.) is amended by adding at the end the following:

1 **"SEC. 399V. GRANTS TO PROMOTE POSITIVE HEALTH BE-**
2 **HAVIORS AND OUTCOMES.**

3 "(a) GRANTS AUTHORIZED.—The Director of the
4 Centers for Disease Control and Prevention, in collabora-
5 tion with the Secretary, shall award grants to eligible enti-
6 ties to promote positive health behaviors and outcomes for
7 populations in medically underserved communities through
8 the use of community health workers.

9 "(b) USE OF FUNDS.—Grants awarded under sub-
10 section (a) shall be used to support community health
11 workers—

12 "(1) to educate, guide, and provide outreach in
13 a community setting regarding health problems prev-
14 alent in medically underserved communities, particu-
15 larly racial and ethnic minority populations;

16 "(2) to educate and provide guidance regarding
17 effective strategies to promote positive health behav-
18 iors and discourage risky health behaviors;

19 "(3) to educate and provide outreach regarding
20 enrollment in health insurance including the Chil-
21 dren's Health Insurance Program under title XXI of
22 the Social Security Act, Medicare under title XVIII
23 of such Act and Medicaid under title XIX of such
24 Act;

25 "(4) to identify, educate, refer, and enroll un-
26 derserved populations to appropriate healthcare

1 agencies and community-based programs and organi-
2 zations in order to increase access to quality
3 healthcare services and to eliminate duplicative care;
4 or

5 ''(5) to educate, guide, and provide home visita-
6 tion services regarding maternal health and prenatal
7 care.

8 ''(c) APPLICATION.—Each eligible entity that desires
9 to receive a grant under subsection (a) shall submit an
10 application to the Secretary, at such time, in such manner,
11 and accompanied by such information as the Secretary
12 may require.

13 ''(d) PRIORITY.—In awarding grants under sub-
14 section (a), the Secretary shall give priority to applicants
15 that—

16 ''(1) propose to target geographic areas—

17 ''(A) with a high percentage of residents
18 who are eligible for health insurance but are
19 uninsured or underinsured;

20 ''(B) with a high percentage of residents
21 who suffer from chronic diseases; or

22 ''(C) with a high infant mortality rate;

23 ''(2) have experience in providing health or
24 health-related social services to individuals who are
25 underserved with respect to such services; and

1 "(3) have documented community activity and
2 experience with community health workers.
3 "(e) COLLABORATION WITH ACADEMIC INSTITU-
4 TIONS AND THE ONE-STOP DELIVERY SYSTEM.—The Sec-
5 retary shall encourage community health worker programs
6 receiving funds under this section to collaborate with aca-
7 demic institutions and one-stop delivery systems under
8 section 134(c) of the Workforce Investment Act of 1998.
9 Nothing in this section shall be construed to require such
10 collaboration.
11 "(f) EVIDENCE-BASED INTERVENTIONS.—The Sec-
12 retary shall encourage community health worker programs
13 receiving funding under this section to implement a proc-
14 ess or an outcome-based payment system that rewards
15 community health workers for connecting underserved
16 populations with the most appropriate services at the most
17 appropriate time. Nothing in this section shall be con-
18 strued to require such a payment.
19 "(g) QUALITY ASSURANCE AND COST EFFECTIVE-
20 NESS.—The Secretary shall establish guidelines for assur-
21 ing the quality of the training and supervision of commu-
22 nity health workers under the programs funded under this
23 section and for assuring the cost-effectiveness of such pro-
24 grams.

1 "(h) MONITORING.—The Secretary shall monitor
2 community health worker programs identified in approved
3 applications under this section and shall determine wheth-
4 er such programs are in compliance with the guidelines
5 established under subsection (g).

6 "(i) TECHNICAL ASSISTANCE.—The Secretary may
7 provide technical assistance to community health worker
8 programs identified in approved applications under this
9 section with respect to planning, developing, and operating
10 programs under the grant.

11 "(j) AUTHORIZATION OF APPROPRIATIONS.—There
12 are authorized to be appropriated, such sums as may be
13 necessary to carry out this section for each of fiscal years
14 2010 through 2014.

15 "(k) DEFINITIONS.—In this section:

16 "(1) COMMUNITY HEALTH WORKER.—The term
17 'community health worker', as defined by the De-
18 partment of Labor as Standard Occupational Classi-
19 fication [21–1094] means an individual who pro-
20 motes health or nutrition within the community in
21 which the individual resides—

22 "(A) by serving as a liaison between com-
23 munities and healthcare agencies;

24 "(B) by providing guidance and social as-
25 sistance to community residents;

"(C) by enhancing community residents' ability to effectively communicate with healthcare providers;

"(D) by providing culturally and linguistically appropriate health or nutrition education;

"(E) by advocating for individual and community health;

"(F) by providing referral and follow-up services or otherwise coordinating care; and

"(G) by proactively identifying and enrolling eligible individuals in Federal, State, local, private or nonprofit health and human services programs.

"(2) COMMUNITY SETTING.—The term 'community setting' means a home or a community organization located in the neighborhood in which a participant in the program under this section resides.

"(3) ELIGIBLE ENTITY.—The term 'eligible entity' means a public or nonprofit private entity (including a State or public subdivision of a State, a public health department, a free health clinic, a hospital, or a Federally-qualified health center (as defined in section 1861(aa) of the Social Security Act)), or a consortium of any such entities.

"(4) MEDICALLY UNDERSERVED COMMUNITY.—The term 'medically underserved community' means a community identified by a State—

"(A) that has a substantial number of individuals who are members of a medically underserved population, as defined by section 330(b)(3); and

"(B) a significant portion of which is a health professional shortage area as designated under section 332.".

SEC. 5314. FELLOWSHIP TRAINING IN PUBLIC HEALTH.

Part E of title VII of the Public Health Service Act (42 U.S.C. 294n et seq.), as amended by section 5206, is further amended by adding at the end the following:

"SEC. 778. FELLOWSHIP TRAINING IN APPLIED PUBLIC HEALTH EPIDEMIOLOGY, PUBLIC HEALTH LABORATORY SCIENCE, PUBLIC HEALTH INFORMATICS, AND EXPANSION OF THE EPIDEMIC INTELLIGENCE SERVICE.

"(a) IN GENERAL.—The Secretary may carry out activities to address documented workforce shortages in State and local health departments in the critical areas of applied public health epidemiology and public health laboratory science and informatics and may expand the Epidemic Intelligence Service.

1 "(b) SPECIFIC USES.—In carrying out subsection
2 (a), the Secretary shall provide for the expansion of exist-
3 ing fellowship programs operated through the Centers for
4 Disease Control and Prevention in a manner that is de-
5 signed to alleviate shortages of the type described in sub-
6 section (a).

7 "(c) OTHER PROGRAMS.—The Secretary may provide
8 for the expansion of other applied epidemiology training
9 programs that meet objectives similar to the objectives of
10 the programs described in subsection (b).

11 "(d) WORK OBLIGATION.—Participation in fellow-
12 ship training programs under this section shall be deemed
13 to be service for purposes of satisfying work obligations
14 stipulated in contracts under section 338I(j).

15 "(e) GENERAL SUPPORT.—Amounts may be used
16 from grants awarded under this section to expand the
17 Public Health Informatics Fellowship Program at the
18 Centers for Disease Control and Prevention to better sup-
19 port all public health systems at all levels of government.

20 "(f) AUTHORIZATION OF APPROPRIATIONS.—There
21 are authorized to be appropriated to carry out this section
22 $39,500,000 for each of fiscal years 2010 through 2013,
23 of which—

"(1) $5,000,000 shall be made available in each such fiscal year for epidemiology fellowship training program activities under subsections (b) and (c);

"(2) $5,000,000 shall be made available in each such fiscal year for laboratory fellowship training programs under subsection (b);

"(3) $5,000,000 shall be made available in each such fiscal year for the Public Health Informatics Fellowship Program under subsection (e); and

"(4) $24,500,000 shall be made available for expanding the Epidemic Intelligence Service under subsection (a).".

SEC. 5315. UNITED STATES PUBLIC HEALTH SCIENCES TRACK.

Title II of the Public Health Service Act (42 U.S.C. 202 et seq.) is amended by adding at the end the following:

"PART D—UNITED STATES PUBLIC HEALTH SCIENCES TRACK

"SEC. 271. ESTABLISHMENT.

"(a) UNITED STATES PUBLIC HEALTH SERVICES TRACK.—

"(1) IN GENERAL.—There is hereby authorized to be established a United States Public Health Sciences Track (referred to in this part as the

'Track'), at sites to be selected by the Secretary, with authority to grant appropriate advanced degrees in a manner that uniquely emphasizes team-based service, public health, epidemiology, and emergency preparedness and response. It shall be so organized as to graduate not less than—

"(A) 150 medical students annually, 10 of whom shall be awarded studentships to the Uniformed Services University of Health Sciences;

"(B) 100 dental students annually;

"(C) 250 nursing students annually;

"(D) 100 public health students annually;

"(E) 100 behavioral and mental health professional students annually;

"(F) 100 physician assistant or nurse practitioner students annually; and

"(G) 50 pharmacy students annually.

"(2) LOCATIONS.—The Track shall be located at existing and accredited, affiliated health professions education training programs at academic health centers located in regions of the United States determined appropriate by the Surgeon General, in consultation with the National Health Care Workforce Commission established in section 5101 of the Patient Protection and Affordable Care Act.

1 "(b) NUMBER OF GRADUATES.—Except as provided
2 in subsection (a), the number of persons to be graduated
3 from the Track shall be prescribed by the Secretary. In
4 so prescribing the number of persons to be graduated from
5 the Track, the Secretary shall institute actions necessary
6 to ensure the maximum number of first-year enrollments
7 in the Track consistent with the academic capacity of the
8 affiliated sites and the needs of the United States for med-
9 ical, dental, and nursing personnel.

10 "(c) DEVELOPMENT.—The development of the Track
11 may be by such phases as the Secretary may prescribe
12 subject to the requirements of subsection (a).

13 "(d) INTEGRATED LONGITUDINAL PLAN.—The Sur-
14 geon General shall develop an integrated longitudinal plan
15 for health professions continuing education throughout the
16 continuum of health-related education, training, and prac-
17 tice. Training under such plan shall emphasize patient-
18 centered, interdisciplinary, and care coordination skills.
19 Experience with deployment of emergency response teams
20 shall be included during the clinical experiences.

21 "(e) FACULTY DEVELOPMENT.—The Surgeon Gen-
22 eral shall develop faculty development programs and cur-
23 ricula in decentralized venues of health care, to balance
24 urban, tertiary, and inpatient venues.

"SEC. 272. ADMINISTRATION.

"(a) IN GENERAL.—The business of the Track shall be conducted by the Surgeon General with funds appropriated for and provided by the Department of Health and Human Services. The National Health Care Workforce Commission shall assist the Surgeon General in an advisory capacity.

"(b) FACULTY.—

"(1) IN GENERAL.—The Surgeon General, after considering the recommendations of the National Health Care Workforce Commission, shall obtain the services of such professors, instructors, and administrative and other employees as may be necessary to operate the Track, but utilize when possible, existing affiliated health professions training institutions. Members of the faculty and staff shall be employed under salary schedules and granted retirement and other related benefits prescribed by the Secretary so as to place the employees of the Track faculty on a comparable basis with the employees of fully accredited schools of the health professions within the United States.

"(2) TITLES.—The Surgeon General may confer academic titles, as appropriate, upon the members of the faculty.

"(3) NONAPPLICATION OF PROVISIONS.—The limitations in section 5373 of title 5, United States Code, shall not apply to the authority of the Surgeon General under paragraph (1) to prescribe salary schedules and other related benefits.

"(c) AGREEMENTS.—The Surgeon General may negotiate agreements with agencies of the Federal Government to utilize on a reimbursable basis appropriate existing Federal medical resources located in the United States (or locations selected in accordance with section 271(a)(2)). Under such agreements the facilities concerned will retain their identities and basic missions. The Surgeon General may negotiate affiliation agreements with accredited universities and health professions training institutions in the United States. Such agreements may include provisions for payments for educational services provided students participating in Department of Health and Human Services educational programs.

"(d) PROGRAMS.—The Surgeon General may establish the following educational programs for Track students:

"(1) Postdoctoral, postgraduate, and technological programs.

1 "(2) A cooperative program for medical, dental,
2 physician assistant, pharmacy, behavioral and men-
3 tal health, public health, and nursing students.
4 "(3) Other programs that the Surgeon General
5 determines necessary in order to operate the Track
6 in a cost-effective manner.
7 "(e) CONTINUING MEDICAL EDUCATION.—The Sur-
8 geon General shall establish programs in continuing med-
9 ical education for members of the health professions to
10 the end that high standards of health care may be main-
11 tained within the United States.
12 "(f) AUTHORITY OF THE SURGEON GENERAL.—
13 "(1) IN GENERAL.—The Surgeon General is au-
14 thorized—
15 "(A) to enter into contracts with, accept
16 grants from, and make grants to any nonprofit
17 entity for the purpose of carrying out coopera-
18 tive enterprises in medical, dental, physician as-
19 sistant, pharmacy, behavioral and mental
20 health, public health, and nursing research,
21 consultation, and education;
22 "(B) to enter into contracts with entities
23 under which the Surgeon General may furnish
24 the services of such professional, technical, or
25 clerical personnel as may be necessary to fulfill

cooperative enterprises undertaken by the Track;

"(C) to accept, hold, administer, invest, and spend any gift, devise, or bequest of personal property made to the Track, including any gift, devise, or bequest for the support of an academic chair, teaching, research, or demonstration project;

"(D) to enter into agreements with entities that may be utilized by the Track for the purpose of enhancing the activities of the Track in education, research, and technological applications of knowledge; and

"(E) to accept the voluntary services of guest scholars and other persons.

"(2) LIMITATION.—The Surgeon General may not enter into any contract with an entity if the contract would obligate the Track to make outlays in advance of the enactment of budget authority for such outlays.

"(3) SCIENTISTS.—Scientists or other medical, dental, or nursing personnel utilized by the Track under an agreement described in paragraph (1) may be appointed to any position within the Track and

may be permitted to perform such duties within the Track as the Surgeon General may approve.

"(4) VOLUNTEER SERVICES.—A person who provides voluntary services under the authority of subparagraph (E) of paragraph (1) shall be considered to be an employee of the Federal Government for the purposes of chapter 81 of title 5, relating to compensation for work-related injuries, and to be an employee of the Federal Government for the purposes of chapter 171 of title 28, relating to tort claims. Such a person who is not otherwise employed by the Federal Government shall not be considered to be a Federal employee for any other purpose by reason of the provision of such services.

"SEC. 273. STUDENTS; SELECTION; OBLIGATION.

"(a) STUDENT SELECTION.—

"(1) IN GENERAL.—Medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, and nursing students at the Track shall be selected under procedures prescribed by the Surgeon General. In so prescribing, the Surgeon General shall consider the recommendations of the National Health Care Workforce Commission.

"(2) PRIORITY.—In developing admissions procedures under paragraph (1), the Surgeon General

shall ensure that such procedures give priority to applicant medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, and nursing students from rural communities and underrepresented minorities.

''(b) CONTRACT AND SERVICE OBLIGATION.—

''(1) CONTRACT.—Upon being admitted to the Track, a medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, or nursing student shall enter into a written contract with the Surgeon General that shall contain—

''(A) an agreement under which—

''(i) subject to subparagraph (B), the Surgeon General agrees to provide the student with tuition (or tuition remission) and a student stipend (described in paragraph (2)) in each school year for a period of years (not to exceed 4 school years) determined by the student, during which period the student is enrolled in the Track at an affiliated or other participating health professions institution pursuant to an agreement between the Track and such institution; and

1 "(ii) subject to subparagraph (B), the
2 student agrees—
3 "(I) to accept the provision of
4 such tuition and student stipend to
5 the student;
6 "(II) to maintain enrollment at
7 the Track until the student completes
8 the course of study involved;
9 "(III) while enrolled in such
10 course of study, to maintain an ac-
11 ceptable level of academic standing
12 (as determined by the Surgeon Gen-
13 eral);
14 "(IV) if pursuing a degree from
15 a school of medicine or osteopathic
16 medicine, dental, public health, or
17 nursing school or a physician assist-
18 ant, pharmacy, or behavioral and
19 mental health professional program,
20 to complete a residency or internship
21 in a specialty that the Surgeon Gen-
22 eral determines is appropriate; and
23 "(V) to serve for a period of time
24 (referred to in this part as the 'period
25 of obligated service') within the Com-

missioned Corps of the Public Health Service equal to 2 years for each school year during which such individual was enrolled at the College, reduced as provided for in paragraph (3);

"(B) a provision that any financial obligation of the United States arising out of a contract entered into under this part and any obligation of the student which is conditioned thereon, is contingent upon funds being appropriated to carry out this part;

"(C) a statement of the damages to which the United States is entitled for the student's breach of the contract; and

"(D) such other statements of the rights and liabilities of the Secretary and of the individual, not inconsistent with the provisions of this part.

"(2) TUITION AND STUDENT STIPEND.—

"(A) TUITION REMISSION RATES.—The Surgeon General, based on the recommendations of the National Health Care Workforce Commission, shall establish Federal tuition remission rates to be used by the Track to pro-

vide reimbursement to affiliated and other participating health professions institutions for the cost of educational services provided by such institutions to Track students. The agreement entered into by such participating institutions under paragraph (1)(A)(i) shall contain an agreement to accept as payment in full the established remission rate under this subparagraph.

"(B) STIPEND.—The Surgeon General, based on the recommendations of the National Health Care Workforce Commission, shall establish and update Federal stipend rates for payment to students under this part.

"(3) REDUCTIONS IN THE PERIOD OF OBLIGATED SERVICE.—The period of obligated service under paragraph (1)(A)(ii)(V) shall be reduced—

"(A) in the case of a student who elects to participate in a high-needs speciality residency (as determined by the National Health Care Workforce Commission), by 3 months for each year of such participation (not to exceed a total of 12 months); and

"(B) in the case of a student who, upon completion of their residency, elects to practice

in a Federal medical facility (as defined in section 781(e)) that is located in a health professional shortage area (as defined in section 332), by 3 months for year of full-time practice in such a facility (not to exceed a total of 12 months).

"(c) SECOND 2 YEARS OF SERVICE.—During the third and fourth years in which a medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, or nursing student is enrolled in the Track, training should be designed to prioritize clinical rotations in Federal medical facilities in health professional shortage areas, and emphasize a balance of hospital and community-based experiences, and training within interdisciplinary teams.

"(d) DENTIST, PHYSICIAN ASSISTANT, PHARMACIST, BEHAVIORAL AND MENTAL HEALTH PROFESSIONAL, PUBLIC HEALTH PROFESSIONAL, AND NURSE TRAINING.—The Surgeon General shall establish provisions applicable with respect to dental, physician assistant, pharmacy, behavioral and mental health, public health, and nursing students that are comparable to those for medical students under this section, including service obligations, tuition support, and stipend support. The Surgeon General shall give priority to health professions training insti-

1 tutions that train medical, dental, physician assistant,
2 pharmacy, behavioral and mental health, public health,
3 and nursing students for some significant period of time
4 together, but at a minimum have a discrete and shared
5 core curriculum.

6 "(e) ELITE FEDERAL DISASTER TEAMS.—The Sur-
7 geon General, in consultation with the Secretary, the Di-
8 rector of the Centers for Disease Control and Prevention,
9 and other appropriate military and Federal government
10 agencies, shall develop criteria for the appointment of
11 highly qualified Track faculty, medical, dental, physician
12 assistant, pharmacy, behavioral and mental health, public
13 health, and nursing students, and graduates to elite Fed-
14 eral disaster preparedness teams to train and to respond
15 to public health emergencies, natural disasters, bioter-
16 rorism events, and other emergencies.

17 "(f) STUDENT DROPPED FROM TRACK IN AFFILIATE
18 SCHOOL.—A medical, dental, physician assistant, phar-
19 macy, behavioral and mental health, public health, or
20 nursing student who, under regulations prescribed by the
21 Surgeon General, is dropped from the Track in an affili-
22 ated school for deficiency in conduct or studies, or for
23 other reasons, shall be liable to the United States for all
24 tuition and stipend support provided to the student.

"SEC. 274. FUNDING.

"Beginning with fiscal year 2010, the Secretary shall transfer from the Public Health and Social Services Emergency Fund such sums as may be necessary to carry out this part.".

Subtitle E—Supporting the Existing Health Care Workforce

SEC. 5401. CENTERS OF EXCELLENCE.

Section 736 of the Public Health Service Act (42 U.S.C. 293) is amended by striking subsection (h) and inserting the following:

"(h) FORMULA FOR ALLOCATIONS.—

"(1) ALLOCATIONS.—Based on the amount appropriated under subsection (i) for a fiscal year, the following subparagraphs shall apply as appropriate:

"(A) IN GENERAL.—If the amounts appropriated under subsection (i) for a fiscal year are $24,000,000 or less—

"(i) the Secretary shall make available $12,000,000 for grants under subsection (a) to health professions schools that meet the conditions described in subsection (c)(2)(A); and

"(ii) and available after grants are made with funds under clause (i), the Secretary shall make available—

"(I) 60 percent of such amount for grants under subsection (a) to health professions schools that meet the conditions described in paragraph (3) or (4) of subsection (c) (including meeting the conditions under subsection (e)); and

"(II) 40 percent of such amount for grants under subsection (a) to health professions schools that meet the conditions described in subsection (c)(5).

"(B) FUNDING IN EXCESS OF $24,000,000.—If amounts appropriated under subsection (i) for a fiscal year exceed $24,000,000 but are less than $30,000,000—

"(i) 80 percent of such excess amounts shall be made available for grants under subsection (a) to health professions schools that meet the requirements described in paragraph (3) or (4) of subsection (c) (including meeting conditions pursuant to subsection (e)); and

"(ii) 20 percent of such excess amount shall be made available for grants

under subsection (a) to health professions schools that meet the conditions described in subsection (c)(5).

"(C) FUNDING IN EXCESS OF $30,000,000.—If amounts appropriated under subsection (i) for a fiscal year exceed $30,000,000 but are less than $40,000,000, the Secretary shall make available—

"(i) not less than $12,000,000 for grants under subsection (a) to health professions schools that meet the conditions described in subsection (c)(2)(A);

"(ii) not less than $12,000,000 for grants under subsection (a) to health professions schools that meet the conditions described in paragraph (3) or (4) of subsection (c) (including meeting conditions pursuant to subsection (e));

"(iii) not less than $6,000,000 for grants under subsection (a) to health professions schools that meet the conditions described in subsection (c)(5); and

"(iv) after grants are made with funds under clauses (i) through (iii), any remaining excess amount for grants under

subsection (a) to health professions schools that meet the conditions described in paragraph (2)(A), (3), (4), or (5) of subsection (c).

"(D) FUNDING IN EXCESS OF $40,000,000.—If amounts appropriated under subsection (i) for a fiscal year are $40,000,000 or more, the Secretary shall make available—

"(i) not less than $16,000,000 for grants under subsection (a) to health professions schools that meet the conditions described in subsection (c)(2)(A);

"(ii) not less than $16,000,000 for grants under subsection (a) to health professions schools that meet the conditions described in paragraph (3) or (4) of subsection (c) (including meeting conditions pursuant to subsection (e));

"(iii) not less than $8,000,000 for grants under subsection (a) to health professions schools that meet the conditions described in subsection (c)(5); and

"(iv) after grants are made with funds under clauses (i) through (iii), any remaining funds for grants under sub-

1 section (a) to health professions schools
2 that meet the conditions described in para-
3 graph (2)(A), (3), (4), or (5) of subsection
4 (c).

5 "(2) NO LIMITATION.—Nothing in this sub-
6 section shall be construed as limiting the centers of
7 excellence referred to in this section to the des-
8 ignated amount, or to preclude such entities from
9 competing for grants under this section.

10 "(3) MAINTENANCE OF EFFORT.—

11 "(A) IN GENERAL.—With respect to activi-
12 ties for which a grant made under this part are
13 authorized to be expended, the Secretary may
14 not make such a grant to a center of excellence
15 for any fiscal year unless the center agrees to
16 maintain expenditures of non-Federal amounts
17 for such activities at a level that is not less
18 than the level of such expenditures maintained
19 by the center for the fiscal year preceding the
20 fiscal year for which the school receives such a
21 grant.

22 "(B) USE OF FEDERAL FUNDS.—With re-
23 spect to any Federal amounts received by a cen-
24 ter of excellence and available for carrying out
25 activities for which a grant under this part is

1 authorized to be expended, the center shall, be-
2 fore expending the grant, expend the Federal
3 amounts obtained from sources other than the
4 grant, unless given prior approval from the Sec-
5 retary.

6 ''(i) AUTHORIZATION OF APPROPRIATIONS.—There
7 are authorized to be appropriated to carry out this sec-
8 tion—

9 ''(1) $50,000,000 for each of the fiscal years
10 2010 through 2015; and

11 ''(2) and such sums as are necessary for each
12 subsequent fiscal year.''.

13 **SEC. 5402. HEALTH CARE PROFESSIONALS TRAINING FOR**
14 **DIVERSITY.**

15 (a) LOAN REPAYMENTS AND FELLOWSHIPS REGARD-
16 ING FACULTY POSITIONS.—Section 738(a)(1) of the Pub-
17 lic Health Service Act (42 U.S.C. 293b(a)(1)) is amended
18 by striking ''$20,000 of the principal and interest of the
19 educational loans of such individuals.'' and inserting
20 ''$30,000 of the principal and interest of the educational
21 loans of such individuals.''.

22 (b) SCHOLARSHIPS FOR DISADVANTAGED STU-
23 DENTS.—Section 740(a) of such Act (42 U.S.C. 293d(a))
24 is amended by striking ''$37,000,000'' and all that follows
25 through ''2002'' and inserting ''$51,000,000 for fiscal

year 2010, and such sums as may be necessary for each of the fiscal years 2011 through 2014''.

(c) REAUTHORIZATION FOR LOAN REPAYMENTS AND FELLOWSHIPS REGARDING FACULTY POSITIONS.—Section 740(b) of such Act (42 U.S.C. 293d(b)) is amended by striking ''appropriated'' and all that follows through the period at the end and inserting ''appropriated, $5,000,000 for each of the fiscal years 2010 through 2014.''.

(d) REAUTHORIZATION FOR EDUCATIONAL ASSISTANCE IN THE HEALTH PROFESSIONS REGARDING INDIVIDUALS FROM A DISADVANTAGED BACKGROUND.—Section 740(c) of such Act (42 U.S.C. 293d(c)) is amended by striking the first sentence and inserting the following: ''For the purpose of grants and contracts under section 739(a)(1), there is authorized to be appropriated $60,000,000 for fiscal year 2010 and such sums as may be necessary for each of the fiscal years 2011 through 2014.''

SEC. 5403. INTERDISCIPLINARY, COMMUNITY-BASED LINKAGES.

(a) AREA HEALTH EDUCATION CENTERS.—Section 751 of the Public Health Service Act (42 U.S.C. 294a) is amended to read as follows:

"SEC. 751. AREA HEALTH EDUCATION CENTERS.

"(a) ESTABLISHMENT OF AWARDS.—The Secretary shall make the following 2 types of awards in accordance with this section:

"(1) INFRASTRUCTURE DEVELOPMENT AWARD.—The Secretary shall make awards to eligible entities to enable such entities to initiate health care workforce educational programs or to continue to carry out comparable programs that are operating at the time the award is made by planning, developing, operating, and evaluating an area health education center program.

"(2) POINT OF SERVICE MAINTENANCE AND ENHANCEMENT AWARD.—The Secretary shall make awards to eligible entities to maintain and improve the effectiveness and capabilities of an existing area health education center program, and make other modifications to the program that are appropriate due to changes in demographics, needs of the populations served, or other similar issues affecting the area health education center program. For the purposes of this section, the term 'Program' refers to the area health education center program.

"(b) ELIGIBLE ENTITIES; APPLICATION.—

"(1) ELIGIBLE ENTITIES.—

"(A) INFRASTRUCTURE DEVELOPMENT.—For purposes of subsection (a)(1), the term 'eligible entity' means a school of medicine or osteopathic medicine, an incorporated consortium of such schools, or the parent institutions of such a school. With respect to a State in which no area health education center program is in operation, the Secretary may award a grant or contract under subsection (a)(1) to a school of nursing.

"(B) POINT OF SERVICE MAINTENANCE AND ENHANCEMENT.—For purposes of subsection (a)(2), the term 'eligible entity' means an entity that has received funds under this section, is operating an area health education center program, including an area health education center or centers, and has a center or centers that are no longer eligible to receive financial assistance under subsection (a)(1).

"(2) APPLICATION.—An eligible entity desiring to receive an award under this section shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

"(c) USE OF FUNDS.—

1 "(1) REQUIRED ACTIVITIES.—An eligible entity
2 shall use amounts awarded under a grant under sub-
3 section (a)(1) or (a)(2) to carry out the following ac-
4 tivities:
5 "(A) Develop and implement strategies, in
6 coordination with the applicable one-stop deliv-
7 ery system under section 134(c) of the Work-
8 force Investment Act of 1998, to recruit indi-
9 viduals from underrepresented minority popu-
10 lations or from disadvantaged or rural back-
11 grounds into health professions, and support
12 such individuals in attaining such careers.
13 "(B) Develop and implement strategies to
14 foster and provide community-based training
15 and education to individuals seeking careers in
16 health professions within underserved areas for
17 the purpose of developing and maintaining a di-
18 verse health care workforce that is prepared to
19 deliver high-quality care, with an emphasis on
20 primary care, in underserved areas or for health
21 disparity populations, in collaboration with
22 other Federal and State health care workforce
23 development programs, the State workforce
24 agency, and local workforce investment boards,
25 and in health care safety net sites.

1 "(C) Prepare individuals to more effec-
2 tively provide health services to underserved
3 areas and health disparity populations through
4 field placements or preceptorships in conjunc-
5 tion with community-based organizations, ac-
6 credited primary care residency training pro-
7 grams, Federally qualified health centers, rural
8 health clinics, public health departments, or
9 other appropriate facilities.
10 "(D) Conduct and participate in inter-
11 disciplinary training that involves physicians,
12 physician assistants, nurse practitioners, nurse
13 midwives, dentists, psychologists, pharmacists,
14 optometrists, community health workers, public
15 and allied health professionals, or other health
16 professionals, as practicable.
17 "(E) Deliver or facilitate continuing edu-
18 cation and information dissemination programs
19 for health care professionals, with an emphasis
20 on individuals providing care in underserved
21 areas and for health disparity populations.
22 "(F) Propose and implement effective pro-
23 gram and outcomes measurement and evalua-
24 tion strategies.

"(G) Establish a youth public health program to expose and recruit high school students into health careers, with a focus on careers in public health.

"(2) INNOVATIVE OPPORTUNITIES.—An eligible entity may use amounts awarded under a grant under subsection (a)(1) or subsection (a)(2) to carry out any of the following activities:

"(A) Develop and implement innovative curricula in collaboration with community-based accredited primary care residency training programs, Federally qualified health centers, rural health clinics, behavioral and mental health facilities, public health departments, or other appropriate facilities, with the goal of increasing the number of primary care physicians and other primary care providers prepared to serve in underserved areas and health disparity populations.

"(B) Coordinate community-based participatory research with academic health centers, and facilitate rapid flow and dissemination of evidence-based health care information, research results, and best practices to improve quality, efficiency, and effectiveness of health

1 care and health care systems within community
2 settings.
3 "(C) Develop and implement other strate-
4 gies to address identified workforce needs and
5 increase and enhance the health care workforce
6 in the area served by the area health education
7 center program.
8 "(d) REQUIREMENTS.—
9 "(1) AREA HEALTH EDUCATION CENTER PRO-
10 GRAM.—In carrying out this section, the Secretary
11 shall ensure the following:
12 "(A) An entity that receives an award
13 under this section shall conduct at least 10 per-
14 cent of clinical education required for medical
15 students in community settings that are re-
16 moved from the primary teaching facility of the
17 contracting institution for grantees that operate
18 a school of medicine or osteopathic medicine. In
19 States in which an entity that receives an
20 award under this section is a nursing school or
21 its parent institution, the Secretary shall alter-
22 natively ensure that—
23 "(i) the nursing school conducts at
24 least 10 percent of clinical education re-
25 quired for nursing students in community

1 settings that are remote from the primary
2 teaching facility of the school; and
3 "(ii) the entity receiving the award
4 maintains a written agreement with a
5 school of medicine or osteopathic medicine
6 to place students from that school in train-
7 ing sites in the area health education cen-
8 ter program area.
9 "(B) An entity receiving funds under sub-
10 section (a)(2) does not distribute such funding
11 to a center that is eligible to receive funding
12 under subsection (a)(1).
13 "(2) AREA HEALTH EDUCATION CENTER.—The
14 Secretary shall ensure that each area health edu-
15 cation center program includes at least 1 area health
16 education center, and that each such center—
17 "(A) is a public or private organization
18 whose structure, governance, and operation is
19 independent from the awardee and the parent
20 institution of the awardee;
21 "(B) is not a school of medicine or osteo-
22 pathic medicine, the parent institution of such
23 a school, or a branch campus or other subunit
24 of a school of medicine or osteopathic medicine

1 or its parent institution, or a consortium of
2 such entities;
3 "(C) designates an underserved area or
4 population to be served by the center which is
5 in a location removed from the main location of
6 the teaching facilities of the schools partici-
7 pating in the program with such center and
8 does not duplicate, in whole or in part, the geo-
9 graphic area or population served by any other
10 center;
11 "(D) fosters networking and collaboration
12 among communities and between academic
13 health centers and community-based centers;
14 "(E) serves communities with a dem-
15 onstrated need of health professionals in part-
16 nership with academic medical centers;
17 "(F) addresses the health care workforce
18 needs of the communities served in coordination
19 with the public workforce investment system;
20 and
21 "(G) has a community-based governing or
22 advisory board that reflects the diversity of the
23 communities involved.
24 "(e) MATCHING FUNDS.—With respect to the costs
25 of operating a program through a grant under this section,

1 to be eligible for financial assistance under this section,
2 an entity shall make available (directly or through con-
3 tributions from State, county or municipal governments,
4 or the private sector) recurring non-Federal contributions
5 in cash or in kind, toward such costs in an amount that
6 is equal to not less than 50 percent of such costs. At least
7 25 percent of the total required non-Federal contributions
8 shall be in cash. An entity may apply to the Secretary
9 for a waiver of not more than 75 percent of the matching
10 fund amount required by the entity for each of the first
11 3 years the entity is funded through a grant under sub-
12 section (a)(1).

13 "(f) LIMITATION.—Not less than 75 percent of the
14 total amount provided to an area health education center
15 program under subsection (a)(1) or (a)(2) shall be allo-
16 cated to the area health education centers participating
17 in the program under this section. To provide needed flexi-
18 bility to newly funded area health education center pro-
19 grams, the Secretary may waive the requirement in the
20 sentence for the first 2 years of a new area health edu-
21 cation center program funded under subsection (a)(1).

22 "(g) AWARD.—An award to an entity under this sec-
23 tion shall be not less than $250,000 annually per area
24 health education center included in the program involved.
25 If amounts appropriated to carry out this section are not

1 sufficient to comply with the preceding sentence, the Sec-
2 retary may reduce the per center amount provided for in
3 such sentence as necessary, provided the distribution es-
4 tablished in subsection (j)(2) is maintained.

5 "(h) PROJECT TERMS.—

6 "(1) IN GENERAL.—Except as provided in para-
7 graph (2), the period during which payments may be
8 made under an award under subsection (a)(1) may
9 not exceed—

10 "(A) in the case of a program, 12 years;
11 or

12 "(B) in the case of a center within a pro-
13 gram, 6 years.

14 "(2) EXCEPTION.—The periods described in
15 paragraph (1) shall not apply to programs receiving
16 point of service maintenance and enhancement
17 awards under subsection (a)(2) to maintain existing
18 centers and activities.

19 "(i) INAPPLICABILITY OF PROVISION.—Notwith-
20 standing any other provision of this title, section 791(a)
21 shall not apply to an area health education center funded
22 under this section.

23 "(j) AUTHORIZATION OF APPROPRIATIONS.—

"(1) IN GENERAL.—There is authorized to be appropriated to carry out this section $125,000,000 for each of the fiscal years 2010 through 2014.

"(2) REQUIREMENTS.—Of the amounts appropriated for a fiscal year under paragraph (1)—

"(A) not more than 35 percent shall be used for awards under subsection (a)(1);

"(B) not less than 60 percent shall be used for awards under subsection (a)(2);

"(C) not more than 1 percent shall be used for grants and contracts to implement outcomes evaluation for the area health education centers; and

"(D) not more than 4 percent shall be used for grants and contracts to provide technical assistance to entities receiving awards under this section.

"(3) CARRYOVER FUNDS.—An entity that receives an award under this section may carry over funds from 1 fiscal year to another without obtaining approval from the Secretary. In no case may any funds be carried over pursuant to the preceding sentence for more than 3 years.

1 "(k) SENSE OF CONGRESS.—It is the sense of the
2 Congress that every State have an area health education
3 center program in effect under this section.".

4 (b) CONTINUING EDUCATIONAL SUPPORT FOR
5 HEALTH PROFESSIONALS SERVING IN UNDERSERVED
6 COMMUNITIES.—Part D of title VII of the Public Health
7 Service Act (42 U.S.C. 294 et seq.) is amended by striking
8 section 752 and inserting the following:

9 **"SEC. 752. CONTINUING EDUCATIONAL SUPPORT FOR**
10 **HEALTH PROFESSIONALS SERVING IN UN-**
11 **DERSERVED COMMUNITIES.**

12 "(a) IN GENERAL.—The Secretary shall make grants
13 to, and enter into contracts with, eligible entities to im-
14 prove health care, increase retention, increase representa-
15 tion of minority faculty members, enhance the practice en-
16 vironment, and provide information dissemination and
17 educational support to reduce professional isolation
18 through the timely dissemination of research findings
19 using relevant resources.

20 "(b) ELIGIBLE ENTITIES.—For purposes of this sec-
21 tion, the term 'eligible entity' means an entity described
22 in section 799(b).

23 "(c) APPLICATION.—An eligible entity desiring to re-
24 ceive an award under this section shall submit to the Sec-

retary an application at such time, in such manner, and containing such information as the Secretary may require.

"(d) USE OF FUNDS.—An eligible entity shall use amounts awarded under a grant or contract under this section to provide innovative supportive activities to enhance education through distance learning, continuing educational activities, collaborative conferences, and electronic and telelearning activities, with priority for primary care.

"(e) AUTHORIZATION.—There is authorized to be appropriated to carry out this section $5,000,000 for each of the fiscal years 2010 through 2014, and such sums as may be necessary for each subsequent fiscal year.".

SEC. 5404. WORKFORCE DIVERSITY GRANTS.

Section 821 of the Public Health Service Act (42 U.S.C. 296m) is amended—

(1) in subsection (a)—

(A) by striking "The Secretary may" and inserting the following:

"(1) AUTHORITY.—The Secretary may";

(B) by striking "pre-entry preparation, and retention activities" and inserting the following: "stipends for diploma or associate degree nurses to enter a bridge or degree completion program, student scholarships or stipends

for accelerated nursing degree programs, pre-entry preparation, advanced education preparation, and retention activities''; and

(2) in subsection (b)—

(A) by striking ''First'' and all that follows through ''including the'' and inserting ''National Advisory Council on Nurse Education and Practice and consult with nursing associations including the National Coalition of Ethnic Minority Nurse Associations,''; and

(B) by inserting before the period the following: '', and other organizations determined appropriate by the Secretary''.

SEC. 5405. PRIMARY CARE EXTENSION PROGRAM.

Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.), as amended by section 5313, is further amended by adding at the end the following:

''SEC. 399W. PRIMARY CARE EXTENSION PROGRAM.

''(a) ESTABLISHMENT, PURPOSE AND DEFINITION.—

''(1) IN GENERAL.—The Secretary, acting through the Director of the Agency for Healthcare Research and Quality, shall establish a Primary Care Extension Program.

1 "(2) PURPOSE.—The Primary Care Extension
2 Program shall provide support and assistance to pri-
3 mary care providers to educate providers about pre-
4 ventive medicine, health promotion, chronic disease
5 management, mental and behavioral health services
6 (including substance abuse prevention and treatment
7 services), and evidence-based and evidence-informed
8 therapies and techniques, in order to enable pro-
9 viders to incorporate such matters into their practice
10 and to improve community health by working with
11 community-based health connectors (referred to in
12 this section as 'Health Extension Agents').
13 "(3) DEFINITIONS.—In this section:
14 "(A) HEALTH EXTENSION AGENT.—The
15 term 'Health Extension Agent' means any local,
16 community-based health worker who facilitates
17 and provides assistance to primary care prac-
18 tices by implementing quality improvement or
19 system redesign, incorporating the principles of
20 the patient-centered medical home to provide
21 high-quality, effective, efficient, and safe pri-
22 mary care and to provide guidance to patients
23 in culturally and linguistically appropriate ways,
24 and linking practices to diverse health system
25 resources.

1 "(B) PRIMARY CARE PROVIDER.—The
2 term 'primary care provider' means a clinician
3 who provides integrated, accessible health care
4 services and who is accountable for addressing
5 a large majority of personal health care needs,
6 including providing preventive and health pro-
7 motion services for men, women, and children
8 of all ages, developing a sustained partnership
9 with patients, and practicing in the context of
10 family and community, as recognized by a State
11 licensing or regulatory authority, unless other-
12 wise specified in this section.
13 "(b) GRANTS TO ESTABLISH STATE HUBS AND
14 LOCAL PRIMARY CARE EXTENSION AGENCIES.—
15 "(1) GRANTS.—The Secretary shall award com-
16 petitive grants to States for the establishment of
17 State- or multistate-level primary care Primary Care
18 Extension Program State Hubs (referred to in this
19 section as 'Hubs').
20 "(2) COMPOSITION OF HUBS.—A Hub estab-
21 lished by a State pursuant to paragraph (1)—
22 "(A) shall consist of, at a minimum, the
23 State health department, the entity responsible
24 for administering the State Medicaid program
25 (if other than the State health department), the

State-level entity administering the Medicare program, and the departments of 1 or more health professions schools in the State that train providers in primary care; and

"(B) may include entities such as hospital associations, primary care practice-based research networks, health professional societies, State primary care associations, State licensing boards, organizations with a contract with the Secretary under section 1153 of the Social Security Act, consumer groups, and other appropriate entities.

"(c) STATE AND LOCAL ACTIVITIES.—

"(1) HUB ACTIVITIES.—Hubs established under a grant under subsection (b) shall—

"(A) submit to the Secretary a plan to coordinate functions with quality improvement organizations and area health education centers if such entities are members of the Hub not described in subsection (b)(2)(A);

"(B) contract with a county- or local-level entity that shall serve as the Primary Care Extension Agency to administer the services described in paragraph (2);

1 "(C) organize and administer grant funds
2 to county- or local-level Primary Care Exten-
3 sion Agencies that serve a catchment area, as
4 determined by the State; and
5 "(D) organize State-wide or multistate net-
6 works of local-level Primary Care Extension
7 Agencies to share and disseminate information
8 and practices.
9 "(2) LOCAL PRIMARY CARE EXTENSION AGENCY
10 ACTIVITIES.—
11 "(A) REQUIRED ACTIVITIES.—Primary
12 Care Extension Agencies established by a Hub
13 under paragraph (1) shall—
14 "(i) assist primary care providers to
15 implement a patient-centered medical home
16 to improve the accessibility, quality, and
17 efficiency of primary care services, includ-
18 ing health homes;
19 "(ii) develop and support primary care
20 learning communities to enhance the dis-
21 semination of research findings for evi-
22 dence-based practice, assess implementa-
23 tion of practice improvement, share best
24 practices, and involve community clinicians
25 in the generation of new knowledge and

1 identification of important questions for
2 research;
3 ''(iii) participate in a national network
4 of Primary Care Extension Hubs and pro-
5 pose how the Primary Care Extension
6 Agency will share and disseminate lessons
7 learned and best practices; and
8 ''(iv) develop a plan for financial sus-
9 tainability involving State, local, and pri-
10 vate contributions, to provide for the re-
11 duction in Federal funds that is expected
12 after an initial 6-year period of program
13 establishment, infrastructure development,
14 and planning.
15 ''(B) DISCRETIONARY ACTIVITIES.—Pri-
16 mary Care Extension Agencies established by a
17 Hub under paragraph (1) may—
18 ''(i) provide technical assistance,
19 training, and organizational support for
20 community health teams established under
21 section 3602 of the Patient Protection and
22 Affordable Care Act;
23 ''(ii) collect data and provision of pri-
24 mary care provider feedback from stand-
25 ardized measurements of processes and

outcomes to aid in continuous performance improvement;

"(iii) collaborate with local health departments, community health centers, tribes and tribal entities, and other community agencies to identify community health priorities and local health workforce needs, and participate in community-based efforts to address the social and primary determinants of health, strengthen the local primary care workforce, and eliminate health disparities;

"(iv) develop measures to monitor the impact of the proposed program on the health of practice enrollees and of the wider community served; and

"(v) participate in other activities, as determined appropriate by the Secretary.

"(d) FEDERAL PROGRAM ADMINISTRATION.—

"(1) GRANTS; TYPES.—Grants awarded under subsection (b) shall be—

"(A) program grants, that are awarded to State or multistate entities that submit fully-developed plans for the implementation of a Hub, for a period of 6 years; or

"(B) planning grants, that are awarded to State or multistate entities with the goal of developing a plan for a Hub, for a period of 2 years.

"(2) APPLICATIONS.—To be eligible for a grant under subsection (b), a State or multistate entity shall submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require.

"(3) EVALUATION.—A State that receives a grant under subsection (b) shall be evaluated at the end of the grant period by an evaluation panel appointed by the Secretary.

"(4) CONTINUING SUPPORT.—After the sixth year in which assistance is provided to a State under a grant awarded under subsection (b), the State may receive additional support under this section if the State program has received satisfactory evaluations with respect to program performance and the merits of the State sustainability plan, as determined by the Secretary.

"(5) LIMITATION.—A State shall not use in excess of 10 percent of the amount received under a grant to carry out administrative activities under

this section. Funds awarded pursuant to this section shall not be used for funding direct patient care.

"(e) REQUIREMENTS ON THE SECRETARY.—In carrying out this section, the Secretary shall consult with the heads of other Federal agencies with demonstrated experience and expertise in health care and preventive medicine, such as the Centers for Disease Control and Prevention, the Substance Abuse and Mental Health Administration, the Health Resources and Services Administration, the National Institutes of Health, the Office of the National Coordinator for Health Information Technology, the Indian Health Service, the Agricultural Cooperative Extension Service of the Department of Agriculture, and other entities, as the Secretary determines appropriate.

"(f) AUTHORIZATION OF APPROPRIATIONS.—To awards grants as provided in subsection (d), there are authorized to be appropriated $120,000,000 for each of fiscal years 2011 and 2012, and such sums as may be necessary to carry out this section for each of fiscal years 2013 through 2014.".

Subtitle F—Strengthening Primary Care and Other Workforce Improvements

SEC. 5501. EXPANDING ACCESS TO PRIMARY CARE SERVICES AND GENERAL SURGERY SERVICES.

(a) INCENTIVE PAYMENT PROGRAM FOR PRIMARY CARE SERVICES.—

(1) IN GENERAL.—Section 1833 of the Social Security Act (42 U.S.C. 1395l) is amended by adding at the end the following new subsection:

"(x) INCENTIVE PAYMENTS FOR PRIMARY CARE SERVICES.—

"(1) IN GENERAL.—In the case of primary care services furnished on or after January 1, 2011, and before January 1, 2016, by a primary care practitioner, in addition to the amount of payment that would otherwise be made for such services under this part, there also shall be paid (on a monthly or quarterly basis) an amount equal to 10 percent of the payment amount for the service under this part.

"(2) DEFINITIONS.—In this subsection:

"(A) PRIMARY CARE PRACTITIONER.—The term 'primary care practitioner' means an individual—

"(i) who—

1 "(I) is a physician (as described
2 in section 1861(r)(1)) who has a pri-
3 mary specialty designation of family
4 medicine, internal medicine, geriatric
5 medicine, or pediatric medicine; or
6 "(II) is a nurse practitioner, clin-
7 ical nurse specialist, or physician as-
8 sistant (as those terms are defined in
9 section 1861(aa)(5)); and
10 "(ii) for whom primary care services
11 accounted for at least 60 percent of the al-
12 lowed charges under this part for such
13 physician or practitioner in a prior period
14 as determined appropriate by the Sec-
15 retary.
16 "(B) PRIMARY CARE SERVICES.—The term
17 'primary care services' means services identi-
18 fied, as of January 1, 2009, by the following
19 HCPCS codes (and as subsequently modified by
20 the Secretary):
21 "(i) 99201 through 99215.
22 "(ii) 99304 through 99340.
23 "(iii) 99341 through 99350.
24 "(3) COORDINATION WITH OTHER PAY-
25 MENTS.—The amount of the additional payment for

a service under this subsection and subsection (m) shall be determined without regard to any additional payment for the service under subsection (m) and this subsection, respectively.

"(4) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise, respecting the identification of primary care practitioners under this subsection.".

(2) CONFORMING AMENDMENT.—Section 1834(g)(2)(B) of the Social Security Act (42 U.S.C. 1395m(g)(2)(B)) is amended by adding at the end the following sentence: "Section 1833(x) shall not be taken into account in determining the amounts that would otherwise be paid pursuant to the preceding sentence.".

(b) INCENTIVE PAYMENT PROGRAM FOR MAJOR SURGICAL PROCEDURES FURNISHED IN HEALTH PROFESSIONAL SHORTAGE AREAS.—

(1) IN GENERAL.—Section 1833 of the Social Security Act (42 U.S.C. 1395l), as amended by subsection (a)(1), is amended by adding at the end the following new subsection:

1 "(y) INCENTIVE PAYMENTS FOR MAJOR SURGICAL
2 PROCEDURES FURNISHED IN HEALTH PROFESSIONAL
3 SHORTAGE AREAS.—
4 "(1) IN GENERAL.—In the case of major sur-
5 gical procedures furnished on or after January 1,
6 2011, and before January 1, 2016, by a general sur-
7 geon in an area that is designated (under section
8 332(a)(1)(A) of the Public Health Service Act) as a
9 health professional shortage area as identified by the
10 Secretary prior to the beginning of the year involved,
11 in addition to the amount of payment that would
12 otherwise be made for such services under this part,
13 there also shall be paid (on a monthly or quarterly
14 basis) an amount equal to 10 percent of the pay-
15 ment amount for the service under this part.
16 "(2) DEFINITIONS.—In this subsection:
17 "(A) GENERAL SURGEON.—In this sub-
18 section, the term 'general surgeon' means a
19 physician (as described in section 1861(r)(1))
20 who has designated CMS specialty code 02–
21 General Surgery as their primary specialty code
22 in the physician's enrollment under section
23 1866(j).
24 "(B) MAJOR SURGICAL PROCEDURES.—
25 The term 'major surgical procedures' means

1 physicians' services which are surgical proce-
2 dures for which a 10-day or 90-day global pe-
3 riod is used for payment under the fee schedule
4 under section 1848(b).

5 ''(3) COORDINATION WITH OTHER PAY-
6 MENTS.—The amount of the additional payment for
7 a service under this subsection and subsection (m)
8 shall be determined without regard to any additional
9 payment for the service under subsection (m) and
10 this subsection, respectively.

11 ''(4) APPLICATION.—The provisions of para-
12 graph (2) and (4) of subsection (m) shall apply to
13 the determination of additional payments under this
14 subsection in the same manner as such provisions
15 apply to the determination of additional payments
16 under subsection (m).''.

17 (2) CONFORMING AMENDMENT.—Section
18 1834(g)(2)(B) of the Social Security Act (42 U.S.C.
19 1395m(g)(2)(B)), as amended by subsection (a)(2),
20 is amended by striking ''Section 1833(x)'' and in-
21 serting ''Subsections (x) and (y) of section 1833'' in
22 the last sentence.

23 (c) BUDGET-NEUTRALITY ADJUSTMENT.—Section
24 1848(c)(2)(B) of the Social Security Act (42 U.S.C.

1395w–4(c)(2)(B)) is amended by adding at the end the following new clause:

"(vii) ADJUSTMENT FOR CERTAIN PHYSICIAN INCENTIVE PAYMENTS.—Fifty percent of the additional expenditures under this part attributable to subsections (x) and (y) of section 1833 for a year (as estimated by the Secretary) shall be taken into account in applying clause (ii)(II) for 2011 and subsequent years. In lieu of applying the budget-neutrality adjustments required under clause (ii)(II) to relative value units to account for such costs for the year, the Secretary shall apply such budget-neutrality adjustments to the conversion factor otherwise determined for the year. For 2011 and subsequent years, the Secretary shall increase the incentive payment otherwise applicable under section 1833(m) by a percent estimated to be equal to the additional expenditures estimated under the first sentence of this clause for such year that is applicable to physicians who primarily furnish services in areas designated (under section

332(a)(1)(A) of the Public Health Service Act) as health professional shortage areas.''.

SEC. 5502. MEDICARE FEDERALLY QUALIFIED HEALTH CENTER IMPROVEMENTS.

(a) EXPANSION OF MEDICARE-COVERED PREVENTIVE SERVICES AT FEDERALLY QUALIFIED HEALTH CENTERS.—

(1) IN GENERAL.—Section 1861(aa)(3)(A) of the Social Security Act (42 U.S.C. 1395w (aa)(3)(A)) is amended to read as follows:

''(A) services of the type described subparagraphs (A) through (C) of paragraph (1) and preventive services (as defined in section 1861(ddd)(3)); and''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to services furnished on or after January 1, 2011.

(b) PROSPECTIVE PAYMENT SYSTEM FOR FEDERALLY QUALIFIED HEALTH CENTERS.—Section 1834 of the Social Security Act (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

''(n) DEVELOPMENT AND IMPLEMENTATION OF PROSPECTIVE PAYMENT SYSTEM.—

''(1) DEVELOPMENT.—

"(A) IN GENERAL.—The Secretary shall develop a prospective payment system for payment for Federally qualified health services furnished by Federally qualified health centers under this title. Such system shall include a process for appropriately describing the services furnished by Federally qualified health centers.

"(B) COLLECTION OF DATA AND EVALUATION.—The Secretary shall require Federally qualified health centers to submit to the Secretary such information as the Secretary may require in order to develop and implement the prospective payment system under this paragraph and paragraph (2), respectively, including the reporting of services using HCPCS codes.

"(2) IMPLEMENTATION.—

"(A) IN GENERAL.—Notwithstanding section 1833(a)(3)(B), the Secretary shall provide, for cost reporting periods beginning on or after October 1, 2014, for payments for Federally qualified health services furnished by Federally qualified health centers under this title in accordance with the prospective payment system developed by the Secretary under paragraph (1).

"(B) PAYMENTS.—

"(i) INITIAL PAYMENTS.—The Secretary shall implement such prospective payment system so that the estimated amount of expenditures under this title for Federally qualified health services in the first year that the prospective payment system is implemented is equal to 103 percent of the estimated amount of expenditures under this title that would have occurred for such services in such year if the system had not been implemented.

"(ii) PAYMENTS IN SUBSEQUENT YEARS.—In the year after the first year of implementation of such system, and in each subsequent year, the payment rate for Federally qualified health services furnished in the year shall be equal to the payment rate established for such services furnished in the preceding year under this subparagraph increased by the percentage increase in the MEI (as defined in 1842(i)(3)) for the year involved.".

SEC. 5503. DISTRIBUTION OF ADDITIONAL RESIDENCY POSITIONS.

(a) IN GENERAL.—Section 1886(h) of the Social Security Act (42 U.S.C. 1395ww(h)) is amended—

(1) in paragraph (4)(F)(i), by striking ''paragraph (7)'' and inserting ''paragraphs (7) and (8)'';

(2) in paragraph (4)(H)(i), by striking ''paragraph (7)'' and inserting ''paragraphs (7) and (8)'';

(3) in paragraph (7)(E), by inserting ''or paragraph (8)'' before the period at the end; and

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

''(8) DISTRIBUTION OF ADDITIONAL RESIDENCY POSITIONS.—

''(A) REDUCTIONS IN LIMIT BASED ON UNUSED POSITIONS.—

''(i) IN GENERAL.—Except as provided in clause (ii), if a hospital's reference resident level (as defined in subparagraph (H)(i)) is less than the otherwise applicable resident limit (as defined in subparagraph (H)(iii)), effective for portions of cost reporting periods occurring on or after July 1, 2011, the otherwise applicable resident limit shall be reduced by 65 percent of the difference between such otherwise

applicable resident limit and such reference resident level.

"(ii) EXCEPTIONS.—This subparagraph shall not apply to—

"(I) a hospital located in a rural area (as defined in subsection (d)(2)(D)(ii)) with fewer than 250 acute care inpatient beds;

"(II) a hospital that was part of a qualifying entity which had a voluntary residency reduction plan approved under paragraph (6)(B) or under the authority of section 402 of Public Law 90–248, if the hospital demonstrates to the Secretary that it has a specified plan in place for filling the unused positions by not later than 2 years after the date of enactment of this paragraph; or

"(III) a hospital described in paragraph (4)(H)(v).

"(B) DISTRIBUTION.—

"(i) IN GENERAL.—The Secretary shall increase the otherwise applicable resident limit for each qualifying hospital that

1 submits an application under this subpara-
2 graph by such number as the Secretary
3 may approve for portions of cost reporting
4 periods occurring on or after July 1, 2011.
5 The aggregate number of increases in the
6 otherwise applicable resident limit under
7 this subparagraph shall be equal to the ag-
8 gregate reduction in such limits attrib-
9 utable to subparagraph (A) (as estimated
10 by the Secretary).

11 ''(ii) REQUIREMENTS.—Subject to
12 clause (iii), a hospital that receives an in-
13 crease in the otherwise applicable resident
14 limit under this subparagraph shall ensure,
15 during the 5-year period beginning on the
16 date of such increase, that—

17 ''(I) the number of full-time
18 equivalent primary care residents, as
19 defined in paragraph (5)(H) (as de-
20 termined by the Secretary), excluding
21 any additional positions under sub-
22 clause (II), is not less than the aver-
23 age number of full-time equivalent
24 primary care residents (as so deter-
25 mined) during the 3 most recent cost

reporting periods ending prior to the date of enactment of this paragraph; and

"(II) not less than 75 percent of the positions attributable to such increase are in a primary care or general surgery residency (as determined by the Secretary).

The Secretary may determine whether a hospital has met the requirements under this clause during such 5-year period in such manner and at such time as the Secretary determines appropriate, including at the end of such 5-year period.

"(iii) REDISTRIBUTION OF POSITIONS IF HOSPITAL NO LONGER MEETS CERTAIN REQUIREMENTS.—In the case where the Secretary determines that a hospital described in clause (ii) does not meet either of the requirements under subclause (I) or (II) of such clause, the Secretary shall—

"(I) reduce the otherwise applicable resident limit of the hospital by the amount by which such limit was increased under this paragraph; and

"(II) provide for the distribution of positions attributable to such reduction in accordance with the requirements of this paragraph.

"(C) CONSIDERATIONS IN REDISTRIBUTION.—In determining for which hospitals the increase in the otherwise applicable resident limit is provided under subparagraph (B), the Secretary shall take into account—

"(i) the demonstration likelihood of the hospital filling the positions made available under this paragraph within the first 3 cost reporting periods beginning on or after July 1, 2011, as determined by the Secretary; and

"(ii) whether the hospital has an accredited rural training track (as described in paragraph (4)(H)(iv)).

"(D) PRIORITY FOR CERTAIN AREAS.—In determining for which hospitals the increase in the otherwise applicable resident limit is provided under subparagraph (B), subject to subparagraph (E), the Secretary shall distribute the increase to hospitals based on the following factors:

"(i) Whether the hospital is located in a State with a resident-to-population ratio in the lowest quartile (as determined by the Secretary).

"(ii) Whether the hospital is located in a State, a territory of the United States, or the District of Columbia that is among the top 10 States, territories, or Districts in terms of the ratio of—

"(I) the total population of the State, territory, or District living in an area designated (under such section 332(a)(1)(A)) as a health professional shortage area (as of the date of enactment of this paragraph); to

"(II) the total population of the State, territory, or District (as determined by the Secretary based on the most recent available population data published by the Bureau of the Census).

"(iii) Whether the hospital is located in a rural area (as defined in subsection (d)(2)(D)(ii)).

"(E) RESERVATION OF POSITIONS FOR CERTAIN HOSPITALS.—

"(i) IN GENERAL.—Subject to clause (ii), the Secretary shall reserve the positions available for distribution under this paragraph as follows:

"(I) 70 percent of such positions for distribution to hospitals described in clause (i) of subparagraph (D).

"(II) 30 percent of such positions for distribution to hospitals described in clause (ii) and (iii) of such subparagraph.

"(ii) EXCEPTION IF POSITIONS NOT REDISTRIBUTED BY JULY 1, 2011.—In the case where the Secretary does not distribute positions to hospitals in accordance with clause (i) by July 1, 2011, the Secretary shall distribute such positions to other hospitals in accordance with the considerations described in subparagraph (C) and the priority described in subparagraph (D).

"(F) LIMITATION.—A hospital may not receive more than 75 full-time equivalent additional residency positions under this paragraph.

"(G) APPLICATION OF PER RESIDENT AMOUNTS FOR PRIMARY CARE AND NONPRIMARY CARE.—With respect to additional residency positions in a hospital attributable to the increase provided under this paragraph, the approved FTE per resident amounts are deemed to be equal to the hospital per resident amounts for primary care and nonprimary care computed under paragraph (2)(D) for that hospital.

"(H) DEFINITIONS.—In this paragraph:

"(i) REFERENCE RESIDENT LEVEL.—The term 'reference resident level' means, with respect to a hospital, the highest resident level for any of the 3 most recent cost reporting periods (ending before the date of the enactment of this paragraph) of the hospital for which a cost report has been settled (or, if not, submitted (subject to audit)), as determined by the Secretary.

"(ii) RESIDENT LEVEL.—The term 'resident level' has the meaning given such term in paragraph (7)(C)(i).

"(iii) OTHERWISE APPLICABLE RESIDENT LIMIT.—The term 'otherwise applicable resident limit' means, with respect to a hospital, the limit otherwise applicable under subparagraphs (F)(i) and (H) of paragraph (4) on the resident level for the hospital determined without regard to this paragraph but taking into account paragraph (7)(A).".

(b) IME.—

(1) IN GENERAL.—Section 1886(d)(5)(B)(v) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)(v)), in the second sentence, is amended—

(A) by striking "subsection (h)(7)" and inserting "subsections (h)(7) and (h)(8)"; and

(B) by striking "it applies" and inserting "they apply".

(2) CONFORMING AMENDMENT.—Section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) is amended by adding at the end the following clause:

"(x) For discharges occurring on or after July 1, 2011, insofar as an additional payment amount under this subparagraph is attributable to resident

positions distributed to a hospital under subsection (h)(8)(B), the indirect teaching adjustment factor shall be computed in the same manner as provided under clause (ii) with respect to such resident positions.''.

(c) CONFORMING AMENDMENT.—Section 422(b)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173) is amended by striking ''section 1886(h)(7)'' and all that follows and inserting ''paragraphs (7) and (8) of subsection (h) of section 1886 of the Social Security Act''.

SEC. 5504. COUNTING RESIDENT TIME IN NONPROVIDER SETTINGS.

(a) GME.—Section 1886(h)(4)(E) of the Social Security Act (42 U.S.C. 1395ww(h)(4)(E)) is amended—

(1) by striking ''shall be counted and that all the time'' and inserting ''shall be counted and that—

''(i) effective for cost reporting periods beginning before July 1, 2010, all the time;'';

(2) in clause (i), as inserted by paragraph (1), by striking the period at the end and inserting ''; and'';

(3) by inserting after clause (i), as so inserted, the following new clause:

"(ii) effective for cost reporting periods beginning on or after July 1, 2010, all the time so spent by a resident shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed, if a hospital incurs the costs of the stipends and fringe benefits of the resident during the time the resident spends in that setting. If more than one hospital incurs these costs, either directly or through a third party, such hospitals shall count a proportional share of the time, as determined by written agreement between the hospitals, that a resident spends training in that setting."; and

(4) by adding at the end the following flush sentence:

"Any hospital claiming under this subparagraph for time spent in a nonprovider setting shall maintain and make available to the Secretary records regarding the amount of such time and such amount in comparison with

1 amounts of such time in such base year as the
2 Secretary shall specify.''.
3 (b) IME.—Section 1886(d)(5)(B)(iv) of the Social
4 Security Act (42 U.S.C. 1395ww(d)(5)) is amended—
5 (1) by striking ''(iv) Effective for discharges oc-
6 curring on or after October 1, 1997'' and inserting
7 ''(iv)(I) Effective for discharges occurring on or
8 after October 1, 1997, and before July 1, 2010'';
9 and
10 (2) by inserting after clause (I), as inserted by
11 paragraph (1), the following new subparagraph:
12 ''(II) Effective for discharges occurring on or
13 after July 1, 2010, all the time spent by an intern
14 or resident in patient care activities in a nonprovider
15 setting shall be counted towards the determination
16 of full-time equivalency if a hospital incurs the costs
17 of the stipends and fringe benefits of the intern or
18 resident during the time the intern or resident
19 spends in that setting. If more than one hospital in-
20 curs these costs, either directly or through a third
21 party, such hospitals shall count a proportional
22 share of the time, as determined by written agree-
23 ment between the hospitals, that a resident spends
24 training in that setting.''.

(c) APPLICATION.—The amendments made by this section shall not be applied in a manner that requires reopening of any settled hospital cost reports as to which there is not a jurisdictionally proper appeal pending as of the date of the enactment of this Act on the issue of payment for indirect costs of medical education under section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) or for direct graduate medical education costs under section 1886(h) of such Act (42 U.S.C. 1395ww(h)).

SEC. 5505. RULES FOR COUNTING RESIDENT TIME FOR DIDACTIC AND SCHOLARLY ACTIVITIES AND OTHER ACTIVITIES.

(a) GME.—Section 1886(h) of the Social Security Act (42 U.S.C. 1395ww(h)), as amended by section 5504, is amended—

(1) in paragraph (4)—

(A) in subparagraph (E), by striking ''Such rules'' and inserting ''Subject to subparagraphs (J) and (K), such rules''; and

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

''(J) TREATMENT OF CERTAIN NONPROVIDER AND DIDACTIC ACTIVITIES.—Such rules shall provide that all time spent by an intern or

1 resident in an approved medical residency train-
2 ing program in a nonprovider setting that is
3 primarily engaged in furnishing patient care (as
4 defined in paragraph (5)(K)) in non-patient
5 care activities, such as didactic conferences and
6 seminars, but not including research not associ-
7 ated with the treatment or diagnosis of a par-
8 ticular patient, as such time and activities are
9 defined by the Secretary, shall be counted to-
10 ward the determination of full-time equivalency.
11 ''(K) TREATMENT OF CERTAIN OTHER AC-
12 TIVITIES.—In determining the hospital's num-
13 ber of full-time equivalent residents for pur-
14 poses of this subsection, all the time that is
15 spent by an intern or resident in an approved
16 medical residency training program on vacation,
17 sick leave, or other approved leave, as such time
18 is defined by the Secretary, and that does not
19 prolong the total time the resident is partici-
20 pating in the approved program beyond the nor-
21 mal duration of the program shall be counted
22 toward the determination of full-time equiva-
23 lency.''; and
24 (2) in paragraph (5), by adding at the end the
25 following new subparagraph:

"(K) NONPROVIDER SETTING THAT IS PRIMARILY ENGAGED IN FURNISHING PATIENT CARE.—The term 'nonprovider setting that is primarily engaged in furnishing patient care' means a nonprovider setting in which the primary activity is the care and treatment of patients, as defined by the Secretary.".

(b) IME DETERMINATIONS.—Section 1886(d)(5)(B) of such Act (42 U.S.C. 1395ww(d)(5)(B)) is amended by adding at the end the following new clause:

"(x)(I) The provisions of subparagraph (K) of subsection (h)(4) shall apply under this subparagraph in the same manner as they apply under such subsection.

"(II) In determining the hospital's number of full-time equivalent residents for purposes of this subparagraph, all the time spent by an intern or resident in an approved medical residency training program in non-patient care activities, such as didactic conferences and seminars, as such time and activities are defined by the Secretary, that occurs in the hospital shall be counted toward the determination of full-time equivalency if the hospital—

1 ''(aa) is recognized as a sub-
2 section (d) hospital;
3 ''(bb) is recognized as a sub-
4 section (d) Puerto Rico hospital;
5 ''(cc) is reimbursed under a reim-
6 bursement system authorized under
7 section 1814(b)(3); or
8 ''(dd) is a provider-based hospital
9 outpatient department.
10 ''(III) In determining the hospital's
11 number of full-time equivalent residents
12 for purposes of this subparagraph, all the
13 time spent by an intern or resident in an
14 approved medical residency training pro-
15 gram in research activities that are not as-
16 sociated with the treatment or diagnosis of
17 a particular patient, as such time and ac-
18 tivities are defined by the Secretary, shall
19 not be counted toward the determination of
20 full-time equivalency.''.
21 (c) EFFECTIVE DATES.—
22 (1) IN GENERAL.—Except as otherwise pro-
23 vided, the Secretary of Health and Human Services
24 shall implement the amendments made by this sec-

tion in a manner so as to apply to cost reporting periods beginning on or after January 1, 1983.

(2) GME.—Section 1886(h)(4)(J) of the Social Security Act, as added by subsection (a)(1)(B), shall apply to cost reporting periods beginning on or after July 1, 2009.

(3) IME.—Section 1886(d)(5)(B)(x)(III) of the Social Security Act, as added by subsection (b), shall apply to cost reporting periods beginning on or after October 1, 2001. Such section, as so added, shall not give rise to any inference as to how the law in effect prior to such date should be interpreted.

SEC. 5506. PRESERVATION OF RESIDENT CAP POSITIONS FROM CLOSED HOSPITALS.

(a) GME.—Section 1886(h)(4)(H) of the Social Security Act (42 U.S.C. Section 1395ww(h)(4)(H)) is amended by adding at the end the following new clause:

"(vi) REDISTRIBUTION OF RESIDENCY SLOTS AFTER A HOSPITAL CLOSES.—

"(I) IN GENERAL.—Subject to the succeeding provisions of this clause, the Secretary shall, by regulation, establish a process under which, in the case where a hospital (other than a hospital described in clause

(v)) with an approved medical residency program closes on or after a date that is 2 years before the date of enactment of this clause, the Secretary shall increase the otherwise applicable resident limit under this paragraph for other hospitals in accordance with this clause.

"(II) PRIORITY FOR HOSPITALS IN CERTAIN AREAS.—Subject to the succeeding provisions of this clause, in determining for which hospitals the increase in the otherwise applicable resident limit is provided under such process, the Secretary shall distribute the increase to hospitals in the following priority order (with preference given within each category to hospitals that are members of the same affiliated group (as defined by the Secretary under clause (ii)) as the closed hospital):

"(aa) First, to hospitals located in the same core-based statistical area as, or a core-based

statistical area contiguous to, the hospital that closed.

"(bb) Second, to hospitals located in the same State as the hospital that closed.

"(cc) Third, to hospitals located in the same region of the country as the hospital that closed.

"(dd) Fourth, only if the Secretary is not able to distribute the increase to hospitals described in item (cc), to qualifying hospitals in accordance with the provisions of paragraph (8).

"(III) REQUIREMENT HOSPITAL LIKELY TO FILL POSITION WITHIN CERTAIN TIME PERIOD.—The Secretary may only increase the otherwise applicable resident limit of a hospital under such process if the Secretary determines the hospital has demonstrated a likelihood of filling the positions made available under this clause within 3 years.

"(IV) LIMITATION.—The aggregate number of increases in the otherwise applicable resident limits for hospitals under this clause shall be equal to the number of resident positions in the approved medical residency programs that closed on or after the date described in subclause (I).

"(V) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to the implementation of this clause.".

(b) IME.—Section 1886(d)(5)(B)(v) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)(v)), in the second sentence, as amended by section 5503, is amended by striking "subsections (h)(7) and (h)(8)" and inserting "subsections (h)(4)(H)(vi), (h)(7), and (h)(8)".

(c) APPLICATION.—The amendments made by this section shall not be applied in a manner that requires reopening of any settled hospital cost reports as to which there is not a jurisdictionally proper appeal pending as of the date of the enactment of this Act on the issue of payment for indirect costs of medical education under section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) or for direct graduate medical edu-

1 cation costs under section 1886(h) of such Act (42 U.S.C.
2 Section 1395ww(h)).

3 (d) EFFECT ON TEMPORARY FTE CAP ADJUST-
4 MENTS.—The Secretary of Health and Human Services
5 shall give consideration to the effect of the amendments
6 made by this section on any temporary adjustment to a
7 hospital's FTE cap under section 413.79(h) of title 42,
8 Code of Federal Regulations (as in effect on the date of
9 enactment of this Act) in order to ensure that there is
10 no duplication of FTE slots. Such amendments shall not
11 affect the application of section 1886(h)(4)(H)(v) of the
12 Social Security Act (42 U.S.C. 1395ww(h)(4)(H)(v)).

13 (e) CONFORMING AMENDMENT.—Section
14 1886(h)(7)(E) of the Social Security Act (42 U.S.C.
15 1395ww(h)(7)(E)), as amended by section 5503(a), is
16 amended by striking ''paragraph or paragraph (8)'' and
17 inserting ''this paragraph, paragraph (8), or paragraph
18 (4)(H)(vi)''.

19 **SEC. 5507. DEMONSTRATION PROJECTS TO ADDRESS**
20 **HEALTH PROFESSIONS WORKFORCE NEEDS;**
21 **EXTENSION OF FAMILY-TO-FAMILY HEALTH**
22 **INFORMATION CENTERS.**

23 (a) AUTHORITY TO CONDUCT DEMONSTRATION
24 PROJECTS.—Title XX of the Social Security Act (42

U.S.C. 1397 et seq.) is amended by adding at the end the following:

"SEC. 2008. DEMONSTRATION PROJECTS TO ADDRESS HEALTH PROFESSIONS WORKFORCE NEEDS.

"(a) DEMONSTRATION PROJECTS TO PROVIDE LOW-INCOME INDIVIDUALS WITH OPPORTUNITIES FOR EDUCATION, TRAINING, AND CAREER ADVANCEMENT TO ADDRESS HEALTH PROFESSIONS WORKFORCE NEEDS.—

"(1) AUTHORITY TO AWARD GRANTS.—The Secretary, in consultation with the Secretary of Labor, shall award grants to eligible entities to conduct demonstration projects that are designed to provide eligible individuals with the opportunity to obtain education and training for occupations in the health care field that pay well and are expected to either experience labor shortages or be in high demand.

"(2) REQUIREMENTS.—

"(A) AID AND SUPPORTIVE SERVICES.—

"(i) IN GENERAL.—A demonstration project conducted by an eligible entity awarded a grant under this section shall, if appropriate, provide eligible individuals participating in the project with financial

1 aid, child care, case management, and
2 other supportive services.
3 "(ii) TREATMENT.—Any aid, services,
4 or incentives provided to an eligible bene-
5 ficiary participating in a demonstration
6 project under this section shall not be con-
7 sidered income, and shall not be taken into
8 account for purposes of determining the in-
9 dividual's eligibility for, or amount of, ben-
10 efits under any means-tested program.
11 "(B) CONSULTATION AND COORDINA-
12 TION.—An eligible entity applying for a grant
13 to carry out a demonstration project under this
14 section shall demonstrate in the application that
15 the entity has consulted with the State agency
16 responsible for administering the State TANF
17 program, the local workforce investment board
18 in the area in which the project is to be con-
19 ducted (unless the applicant is such board), the
20 State workforce investment board established
21 under section 111 of the Workforce Investment
22 Act of 1998, and the State Apprenticeship
23 Agency recognized under the Act of August 16,
24 1937 (commonly known as the 'National Ap-
25 prenticeship Act') (or if no agency has been rec-

ognized in the State, the Office of Apprenticeship of the Department of Labor) and that the project will be carried out in coordination with such entities.

"(C) ASSURANCE OF OPPORTUNITIES FOR INDIAN POPULATIONS.—The Secretary shall award at least 3 grants under this subsection to an eligible entity that is an Indian tribe, tribal organization, or Tribal College or University.

"(3) REPORTS AND EVALUATION.—

"(A) ELIGIBLE ENTITIES.—An eligible entity awarded a grant to conduct a demonstration project under this subsection shall submit interim reports to the Secretary on the activities carried out under the project and a final report on such activities upon the conclusion of the entities' participation in the project. Such reports shall include assessments of the effectiveness of such activities with respect to improving outcomes for the eligible individuals participating in the project and with respect to addressing health professions workforce needs in the areas in which the project is conducted.

"(B) EVALUATION.—The Secretary shall, by grant, contract, or interagency agreement,

1 evaluate the demonstration projects conducted
2 under this subsection. Such evaluation shall in-
3 clude identification of successful activities for
4 creating opportunities for developing and sus-
5 taining, particularly with respect to low-income
6 individuals and other entry-level workers, a
7 health professions workforce that has accessible
8 entry points, that meets high standards for edu-
9 cation, training, certification, and professional
10 development, and that provides increased wages
11 and affordable benefits, including health care
12 coverage, that are responsive to the workforce's
13 needs.

14 "(C) REPORT TO CONGRESS.—The Sec-
15 retary shall submit interim reports and, based
16 on the evaluation conducted under subpara-
17 graph (B), a final report to Congress on the
18 demonstration projects conducted under this
19 subsection.

20 "(4) DEFINITIONS.—In this subsection:

21 "(A) ELIGIBLE ENTITY.—The term 'eligi-
22 ble entity' means a State, an Indian tribe or
23 tribal organization, an institution of higher edu-
24 cation, a local workforce investment board es-
25 tablished under section 117 of the Workforce

Investment Act of 1998, a sponsor of an apprenticeship program registered under the National Apprenticeship Act or a community-based organization.

"(B) ELIGIBLE INDIVIDUAL.—

"(i) IN GENERAL.—The term 'eligible individual' means a individual receiving assistance under the State TANF program.

"(ii) OTHER LOW-INCOME INDIVIDUALS.—Such term may include other low-income individuals described by the eligible entity in its application for a grant under this section.

"(C) INDIAN TRIBE; TRIBAL ORGANIZATION.—The terms 'Indian tribe' and 'tribal organization' have the meaning given such terms in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b).

"(D) INSTITUTION OF HIGHER EDUCATION.—The term 'institution of higher education' has the meaning given that term in section 101 of the Higher Education Act of 1965 (20 U.S.C. 1001).

"(E) STATE.—The term 'State' means each of the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the United States Virgin Islands, Guam, and American Samoa.

"(F) STATE TANF PROGRAM.—The term 'State TANF program' means the temporary assistance for needy families program funded under part A of title IV.

"(G) TRIBAL COLLEGE OR UNIVERSITY.—The term 'Tribal College or University' has the meaning given that term in section 316(b) of the Higher Education Act of 1965 (20 U.S.C. 1059c(b)).

"(b) DEMONSTRATION PROJECT TO DEVELOP TRAINING AND CERTIFICATION PROGRAMS FOR PERSONAL OR HOME CARE AIDES.—

"(1) AUTHORITY TO AWARD GRANTS.—Not later than 18 months after the date of enactment of this section, the Secretary shall award grants to eligible entities that are States to conduct demonstration projects for purposes of developing core training competencies and certification programs for personal or home care aides. The Secretary shall—

"(A) evaluate the efficacy of the core training competencies described in paragraph (3)(A) for newly hired personal or home care aides and the methods used by States to implement such core training competencies in accordance with the issues specified in paragraph (3)(B); and

"(B) ensure that the number of hours of training provided by States under the demonstration project with respect to such core training competencies are not less than the number of hours of training required under any applicable State or Federal law or regulation.

"(2) DURATION.—A demonstration project shall be conducted under this subsection for not less than 3 years.

"(3) CORE TRAINING COMPETENCIES FOR PERSONAL OR HOME CARE AIDES.—

"(A) IN GENERAL.—The core training competencies for personal or home care aides described in this subparagraph include competencies with respect to the following areas:

"(i) The role of the personal or home care aide (including differences between a personal or home care aide employed by an agency and a personal or home care aide

1 employed directly by the health care con-
2 sumer or an independent provider).
3 ''(ii) Consumer rights, ethics, and
4 confidentiality (including the role of proxy
5 decision-makers in the case where a health
6 care consumer has impaired decision-mak-
7 ing capacity).
8 ''(iii) Communication, cultural and
9 linguistic competence and sensitivity, prob-
10 lem solving, behavior management, and re-
11 lationship skills.
12 ''(iv) Personal care skills.
13 ''(v) Health care support.
14 ''(vi) Nutritional support.
15 ''(vii) Infection control.
16 ''(viii) Safety and emergency training.
17 ''(ix) Training specific to an indi-
18 vidual consumer's needs (including older
19 individuals, younger individuals with dis-
20 abilities, individuals with developmental
21 disabilities, individuals with dementia, and
22 individuals with mental and behavioral
23 health needs).
24 ''(x) Self-Care.

"(B) IMPLEMENTATION.—The implementation issues specified in this subparagraph include the following:

"(i) The length of the training.

"(ii) The appropriate trainer to student ratio.

"(iii) The amount of instruction time spent in the classroom as compared to on-site in the home or a facility.

"(iv) Trainer qualifications.

"(v) Content for a 'hands-on' and written certification exam.

"(vi) Continuing education requirements.

"(4) APPLICATION AND SELECTION CRITERIA.—

"(A) IN GENERAL.—

"(i) NUMBER OF STATES.—The Secretary shall enter into agreements with not more than 6 States to conduct demonstration projects under this subsection.

"(ii) REQUIREMENTS FOR STATES.—An agreement entered into under clause (i) shall require that a participating State—

"(I) implement the core training competencies described in paragraph (3)(A); and

"(II) develop written materials and protocols for such core training competencies, including the development of a certification test for personal or home care aides who have completed such training competencies.

"(iii) CONSULTATION AND COLLABORATION WITH COMMUNITY AND VOCATIONAL COLLEGES.—The Secretary shall encourage participating States to consult with community and vocational colleges regarding the development of curricula to implement the project with respect to activities, as applicable, which may include consideration of such colleges as partners in such implementation.

"(B) APPLICATION AND ELIGIBILITY.—A State seeking to participate in the project shall—

"(i) submit an application to the Secretary containing such information and at such time as the Secretary may specify;

1 "(ii) meet the selection criteria estab-
2 lished under subparagraph (C); and
3 "(iii) meet such additional criteria as
4 the Secretary may specify.
5 "(C) SELECTION CRITERIA.—In selecting
6 States to participate in the program, the Sec-
7 retary shall establish criteria to ensure (if appli-
8 cable with respect to the activities involved)—
9 "(i) geographic and demographic di-
10 versity;
11 "(ii) that participating States offer
12 medical assistance for personal care serv-
13 ices under the State Medicaid plan;
14 "(iii) that the existing training stand-
15 ards for personal or home care aides in
16 each participating State—
17 "(I) are different from such
18 standards in the other participating
19 States; and
20 "(II) are different from the core
21 training competencies described in
22 paragraph (3)(A);
23 "(iv) that participating States do not
24 reduce the number of hours of training re-
25 quired under applicable State law or regu-

1 lation after being selected to participate in
2 the project; and
3 "(v) that participating States recruit
4 a minimum number of eligible health and
5 long-term care providers to participate in
6 the project.
7 "(D) TECHNICAL ASSISTANCE.—The Sec-
8 retary shall provide technical assistance to
9 States in developing written materials and pro-
10 tocols for such core training competencies.
11 "(5) EVALUATION AND REPORT.—
12 "(A) EVALUATION.—The Secretary shall
13 develop an experimental or control group test-
14 ing protocol in consultation with an inde-
15 pendent evaluation contractor selected by the
16 Secretary. Such contractor shall evaluate—
17 "(i) the impact of core training com-
18 petencies described in paragraph (3)(A),
19 including curricula developed to implement
20 such core training competencies, for per-
21 sonal or home care aides within each par-
22 ticipating State on job satisfaction, mas-
23 tery of job skills, beneficiary and family
24 caregiver satisfaction with services, and ad-
25 ditional measures determined by the Sec-

1 retary in consultation with the expert
2 panel;
3 "(ii) the impact of providing such core
4 training competencies on the existing
5 training infrastructure and resources of
6 States; and
7 "(iii) whether a minimum number of
8 hours of initial training should be required
9 for personal or home care aides and, if so,
10 what minimum number of hours should be
11 required.
12 "(B) REPORTS.—
13 "(i) REPORT ON INITIAL IMPLEMEN-
14 TATION.—Not later than 2 years after the
15 date of enactment of this section, the Sec-
16 retary shall submit to Congress a report on
17 the initial implementation of activities con-
18 ducted under the demonstration project,
19 including any available results of the eval-
20 uation conducted under subparagraph (A)
21 with respect to such activities, together
22 with such recommendations for legislation
23 or administrative action as the Secretary
24 determines appropriate.

"(ii) FINAL REPORT.—Not later than 1 year after the completion of the demonstration project, the Secretary shall submit to Congress a report containing the results of the evaluation conducted under subparagraph (A), together with such recommendations for legislation or administrative action as the Secretary determines appropriate.

"(6) DEFINITIONS.—In this subsection:

"(A) ELIGIBLE HEALTH AND LONG-TERM CARE PROVIDER.—The term 'eligible health and long-term care provider' means a personal or home care agency (including personal or home care public authorities), a nursing home, a home health agency (as defined in section 1861(o)), or any other health care provider the Secretary determines appropriate which—

"(i) is licensed or authorized to provide services in a participating State; and

"(ii) receives payment for services under title XIX.

"(B) PERSONAL CARE SERVICES.—The term 'personal care services' has the meaning given such term for purposes of title XIX.

1 "(C) PERSONAL OR HOME CARE AIDE.—
2 The term 'personal or home care aide' means
3 an individual who helps individuals who are el-
4 derly, disabled, ill, or mentally disabled (includ-
5 ing an individual with Alzheimer's disease or
6 other dementia) to live in their own home or a
7 residential care facility (such as a nursing
8 home, assisted living facility, or any other facil-
9 ity the Secretary determines appropriate) by
10 providing routine personal care services and
11 other appropriate services to the individual.
12 "(D) STATE.—The term 'State' has the
13 meaning given that term for purposes of title
14 XIX.
15 "(c) FUNDING.—
16 "(1) IN GENERAL.—Subject to paragraph (2),
17 out of any funds in the Treasury not otherwise ap-
18 propriated, there are appropriated to the Secretary
19 to carry out subsections (a) and (b), $85,000,000
20 for each of fiscal years 2010 through 2014.
21 "(2) TRAINING AND CERTIFICATION PROGRAMS
22 FOR PERSONAL AND HOME CARE AIDES.—With re-
23 spect to the demonstration projects under subsection
24 (b), the Secretary shall use $5,000,000 of the
25 amount appropriated under paragraph (1) for each

of fiscal years 2010 through 2012 to carry out such projects. No funds appropriated under paragraph (1) shall be used to carry out demonstration projects under subsection (b) after fiscal year 2012.

''(d) NONAPPLICATION.—

''(1) IN GENERAL.—Except as provided in paragraph (2), the preceding sections of this title shall not apply to grant awarded under this section.

''(2) LIMITATIONS ON USE OF GRANTS.—Section 2005(a) (other than paragraph (6)) shall apply to a grant awarded under this section to the same extent and in the same manner as such section applies to payments to States under this title.''.

(b) EXTENSION OF FAMILY-TO-FAMILY HEALTH INFORMATION CENTERS.—Section 501(c)(1)(A)(iii) of the Social Security Act (42 U.S.C. 701(c)(1)(A)(iii)) is amended by striking ''fiscal year 2009'' and inserting ''each of fiscal years 2009 through 2012''.

SEC. 5508. INCREASING TEACHING CAPACITY.

(a) TEACHING HEALTH CENTERS TRAINING AND ENHANCEMENT.—Part C of title VII of the Public Health Service Act (42 U.S.C. 293k et. seq.), as amended by section 5303, is further amended by inserting after section 749 the following:

"SEC. 749A. TEACHING HEALTH CENTERS DEVELOPMENT GRANTS.

"(a) PROGRAM AUTHORIZED.—The Secretary may award grants under this section to teaching health centers for the purpose of establishing new accredited or expanded primary care residency programs.

"(b) AMOUNT AND DURATION.—Grants awarded under this section shall be for a term of not more than 3 years and the maximum award may not be more than $500,000.

"(c) USE OF FUNDS.—Amounts provided under a grant under this section shall be used to cover the costs of—

"(1) establishing or expanding a primary care residency training program described in subsection (a), including costs associated with—

"(A) curriculum development;

"(B) recruitment, training and retention of residents and faculty:

"(C) accreditation by the Accreditation Council for Graduate Medical Education (ACGME), the American Dental Association (ADA), or the American Osteopathic Association (AOA); and

"(D) faculty salaries during the development phase; and

1 "(2) technical assistance provided by an eligible
2 entity.
3 "(d) APPLICATION.—A teaching health center seek-
4 ing a grant under this section shall submit an application
5 to the Secretary at such time, in such manner, and con-
6 taining such information as the Secretary may require.
7 "(e) PREFERENCE FOR CERTAIN APPLICATIONS.—In
8 selecting recipients for grants under this section, the Sec-
9 retary shall give preference to any such application that
10 documents an existing affiliation agreement with an area
11 health education center program as defined in sections
12 751 and 799B.
13 "(f) DEFINITIONS.—In this section:
14 "(1) ELIGIBLE ENTITY.—The term 'eligible en-
15 tity' means an organization capable of providing
16 technical assistance including an area health edu-
17 cation center program as defined in sections 751
18 and 799B.
19 "(2) PRIMARY CARE RESIDENCY PROGRAM.—
20 The term 'primary care residency program' means
21 an approved graduate medical residency training
22 program (as defined in section 340H) in family med-
23 icine, internal medicine, pediatrics, internal medi-
24 cine-pediatrics, obstetrics and gynecology, psychi-

1 atry, general dentistry, pediatric dentistry, and geri-
2 atrics.
3 "(3) TEACHING HEALTH CENTER.—
4 "(A) IN GENERAL.—The term 'teaching
5 health center' means an entity that—
6 "(i) is a community based, ambula-
7 tory patient care center; and
8 "(ii) operates a primary care resi-
9 dency program.
10 "(B) INCLUSION OF CERTAIN ENTITIES.—
11 Such term includes the following:
12 "(i) A Federally qualified health cen-
13 ter (as defined in section 1905(l)(2)(B), of
14 the Social Security Act).
15 "(ii) A community mental health cen-
16 ter (as defined in section 1861(ff)(3)(B) of
17 the Social Security Act).
18 "(iii) A rural health clinic, as defined
19 in section 1861(aa) of the Social Security
20 Act.
21 "(iv) A health center operated by the
22 Indian Health Service, an Indian tribe or
23 tribal organization, or an urban Indian or-
24 ganization (as defined in section 4 of the
25 Indian Health Care Improvement Act).

"(v) An entity receiving funds under title X of the Public Health Service Act.

"(g) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated, $25,000,000 for fiscal year 2010, $50,000,000 for fiscal year 2011, $50,000,000 for fiscal year 2012, and such sums as may be necessary for each fiscal year thereafter to carry out this section. Not to exceed $5,000,000 annually may be used for technical assistance program grants.".

(b) NATIONAL HEALTH SERVICE CORPS TEACHING CAPACITY.—Section 338C(a) of the Public Health Service Act (42 U.S.C. 254m(a)) is amended to read as follows:

"(a) SERVICE IN FULL-TIME CLINICAL PRACTICE.—Except as provided in section 338D, each individual who has entered into a written contract with the Secretary under section 338A or 338B shall provide service in the full-time clinical practice of such individual's profession as a member of the Corps for the period of obligated service provided in such contract. For the purpose of calculating time spent in full-time clinical practice under this subsection, up to 50 percent of time spent teaching by a member of the Corps may be counted toward his or her service obligation.".

(c) PAYMENTS TO QUALIFIED TEACHING HEALTH CENTERS.—Part D of title III of the Public Health Serv-

ice Act (42 U.S.C. 254b et seq.) is amended by adding at the end the following:

"Subpart XI—Support of Graduate Medical Education in Qualified Teaching Health Centers

"SEC. 340H. PROGRAM OF PAYMENTS TO TEACHING HEALTH CENTERS THAT OPERATE GRADUATE MEDICAL EDUCATION PROGRAMS.

''(a) PAYMENTS.—Subject to subsection (h)(2), the Secretary shall make payments under this section for direct expenses and for indirect expenses to qualified teaching health centers that are listed as sponsoring institutions by the relevant accrediting body for expansion of existing or establishment of new approved graduate medical residency training programs.

''(b) AMOUNT OF PAYMENTS.—

''(1) IN GENERAL.—Subject to paragraph (2), the amounts payable under this section to qualified teaching health centers for an approved graduate medical residency training program for a fiscal year are each of the following amounts:

''(A) DIRECT EXPENSE AMOUNT.—The amount determined under subsection (c) for direct expenses associated with sponsoring approved graduate medical residency training programs.

"(B) INDIRECT EXPENSE AMOUNT.—The amount determined under subsection (d) for indirect expenses associated with the additional costs relating to teaching residents in such programs.

"(2) CAPPED AMOUNT.—

"(A) IN GENERAL.—The total of the payments made to qualified teaching health centers under paragraph (1)(A) or paragraph (1)(B) in a fiscal year shall not exceed the amount of funds appropriated under subsection (g) for such payments for that fiscal year.

"(B) LIMITATION.—The Secretary shall limit the funding of full-time equivalent residents in order to ensure the direct and indirect payments as determined under subsection (c) and (d) do not exceed the total amount of funds appropriated in a fiscal year under subsection (g).

"(c) AMOUNT OF PAYMENT FOR DIRECT GRADUATE MEDICAL EDUCATION.—

"(1) IN GENERAL.—The amount determined under this subsection for payments to qualified teaching health centers for direct graduate expenses relating to approved graduate medical residency

1 training programs for a fiscal year is equal to the
2 product of—
3 "(A) the updated national per resident
4 amount for direct graduate medical education,
5 as determined under paragraph (2); and
6 "(B) the average number of full-time
7 equivalent residents in the teaching health cen-
8 ter's graduate approved medical residency train-
9 ing programs as determined under section
10 1886(h)(4) of the Social Security Act (without
11 regard to the limitation under subparagraph
12 (F) of such section) during the fiscal year.
13 "(2) UPDATED NATIONAL PER RESIDENT
14 AMOUNT FOR DIRECT GRADUATE MEDICAL EDU-
15 CATION.—The updated per resident amount for di-
16 rect graduate medical education for a qualified
17 teaching health center for a fiscal year is an amount
18 determined as follows:
19 "(A) DETERMINATION OF QUALIFIED
20 TEACHING HEALTH CENTER PER RESIDENT
21 AMOUNT.—The Secretary shall compute for
22 each individual qualified teaching health center
23 a per resident amount—
24 "(i) by dividing the national average
25 per resident amount computed under sec-

1 tion 340E(c)(2)(D) into a wage-related
2 portion and a non-wage related portion by
3 applying the proportion determined under
4 subparagraph (B);
5 "(ii) by multiplying the wage-related
6 portion by the factor applied under section
7 1886(d)(3)(E) of the Social Security Act
8 (but without application of section 4410 of
9 the Balanced Budget Act of 1997 (42
10 U.S.C. 1395ww note)) during the pre-
11 ceding fiscal year for the teaching health
12 center's area; and
13 "(iii) by adding the non-wage-related
14 portion to the amount computed under
15 clause (ii).
16 "(B) UPDATING RATE.—The Secretary
17 shall update such per resident amount for each
18 such qualified teaching health center as deter-
19 mined appropriate by the Secretary.
20 "(d) AMOUNT OF PAYMENT FOR INDIRECT MEDICAL
21 EDUCATION.—
22 "(1) IN GENERAL.—The amount determined
23 under this subsection for payments to qualified
24 teaching health centers for indirect expenses associ-
25 ated with the additional costs of teaching residents

for a fiscal year is equal to an amount determined appropriate by the Secretary.

"(2) FACTORS.—In determining the amount under paragraph (1), the Secretary shall—

"(A) evaluate indirect training costs relative to supporting a primary care residency program in qualified teaching health centers; and

"(B) based on this evaluation, assure that the aggregate of the payments for indirect expenses under this section and the payments for direct graduate medical education as determined under subsection (c) in a fiscal year do not exceed the amount appropriated for such expenses as determined in subsection (g).

"(3) INTERIM PAYMENT.—Before the Secretary makes a payment under this subsection pursuant to a determination of indirect expenses under paragraph (1), the Secretary may provide to qualified teaching health centers a payment, in addition to any payment made under subsection (c), for expected indirect expenses associated with the additional costs of teaching residents for a fiscal year, based on an estimate by the Secretary.

1 "(e) CLARIFICATION REGARDING RELATIONSHIP TO
2 OTHER PAYMENTS FOR GRADUATE MEDICAL EDU-
3 CATION.—Payments under this section—
4 "(1) shall be in addition to any payments—
5 "(A) for the indirect costs of medical edu-
6 cation under section 1886(d)(5)(B) of the So-
7 cial Security Act;
8 "(B) for direct graduate medical education
9 costs under section 1886(h) of such Act; and
10 "(C) for direct costs of medical education
11 under section 1886(k) of such Act;
12 "(2) shall not be taken into account in applying
13 the limitation on the number of total full-time equiv-
14 alent residents under subparagraphs (F) and (G) of
15 section 1886(h)(4) of such Act and clauses (v),
16 (vi)(I), and (vi)(II) of section 1886(d)(5)(B) of such
17 Act for the portion of time that a resident rotates
18 to a hospital; and
19 "(3) shall not include the time in which a resi-
20 dent is counted toward full-time equivalency by a
21 hospital under paragraph (2) or under section
22 1886(d)(5)(B)(iv) of the Social Security Act, section
23 1886(h)(4)(E) of such Act, or section 340E of this
24 Act.

1 "(f) RECONCILIATION.—The Secretary shall deter-
2 mine any changes to the number of residents reported by
3 a hospital in the application of the hospital for the current
4 fiscal year to determine the final amount payable to the
5 hospital for the current fiscal year for both direct expense
6 and indirect expense amounts. Based on such determina-
7 tion, the Secretary shall recoup any overpayments made
8 to pay any balance due to the extent possible. The final
9 amount so determined shall be considered a final inter-
10 mediary determination for the purposes of section 1878
11 of the Social Security Act and shall be subject to adminis-
12 trative and judicial review under that section in the same
13 manner as the amount of payment under section 1186(d)
14 of such Act is subject to review under such section.

15 "(g) FUNDING.—To carry out this section, there are
16 appropriated such sums as may be necessary, not to ex-
17 ceed $230,000,000, for the period of fiscal years 2011
18 through 2015.

19 "(h) ANNUAL REPORTING REQUIRED.—

20 "(1) ANNUAL REPORT.—The report required
21 under this paragraph for a qualified teaching health
22 center for a fiscal year is a report that includes (in
23 a form and manner specified by the Secretary) the
24 following information for the residency academic
25 year completed immediately prior to such fiscal year:

"(A) The types of primary care resident approved training programs that the qualified teaching health center provided for residents.

"(B) The number of approved training positions for residents described in paragraph (4).

"(C) The number of residents described in paragraph (4) who completed their residency training at the end of such residency academic year and care for vulnerable populations living in underserved areas.

"(D) Other information as deemed appropriate by the Secretary.

"(2) AUDIT AUTHORITY; LIMITATION ON PAYMENT.—

"(A) AUDIT AUTHORITY.—The Secretary may audit a qualified teaching health center to ensure the accuracy and completeness of the information submitted in a report under paragraph (1).

"(B) LIMITATION ON PAYMENT.—A teaching health center may only receive payment in a cost reporting period for a number of such resident positions that is greater than the base level of primary care resident positions, as determined by the Secretary. For purposes of this

subparagraph, the 'base level of primary care residents' for a teaching health center is the level of such residents as of a base period.

"(3) REDUCTION IN PAYMENT FOR FAILURE TO REPORT.—

"(A) IN GENERAL.—The amount payable under this section to a qualified teaching health center for a fiscal year shall be reduced by at least 25 percent if the Secretary determines that—

"(i) the qualified teaching health center has failed to provide the Secretary, as an addendum to the qualified teaching health center's application under this section for such fiscal year, the report required under paragraph (1) for the previous fiscal year; or

"(ii) such report fails to provide complete and accurate information required under any subparagraph of such paragraph.

"(B) NOTICE AND OPPORTUNITY TO PROVIDE ACCURATE AND MISSING INFORMATION.—Before imposing a reduction under subparagraph (A) on the basis of a qualified teaching

health center's failure to provide complete and accurate information described in subparagraph (A)(ii), the Secretary shall provide notice to the teaching health center of such failure and the Secretary's intention to impose such reduction and shall provide the teaching health center with the opportunity to provide the required information within the period of 30 days beginning on the date of such notice. If the teaching health center provides such information within such period, no reduction shall be made under subparagraph (A) on the basis of the previous failure to provide such information.

''(4) RESIDENTS.—The residents described in this paragraph are those who are in part-time or full-time equivalent resident training positions at a qualified teaching health center in any approved graduate medical residency training program.

''(i) REGULATIONS.—The Secretary shall promulgate regulations to carry out this section.

''(j) DEFINITIONS.—In this section:

''(1) APPROVED GRADUATE MEDICAL RESIDENCY TRAINING PROGRAM.—The term 'approved graduate medical residency training program' means

a residency or other postgraduate medical training program—

"(A) participation in which may be counted toward certification in a specialty or subspecialty and includes formal postgraduate training programs in geriatric medicine approved by the Secretary; and

"(B) that meets criteria for accreditation (as established by the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, or the American Dental Association).

"(2) PRIMARY CARE RESIDENCY PROGRAM.—The term 'primary care residency program' has the meaning given that term in section 749A.

"(3) QUALIFIED TEACHING HEALTH CENTER.—The term 'qualified teaching health center' has the meaning given the term 'teaching health center' in section 749A.".

SEC. 5509. GRADUATE NURSE EDUCATION DEMONSTRATION.

(a) IN GENERAL.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—The Secretary shall establish a graduate nurse education demonstra-

tion under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) under which an eligible hospital may receive payment for the hospital's reasonable costs (described in paragraph (2)) for the provision of qualified clinical training to advance practice nurses.

(B) NUMBER.—The demonstration shall include up to 5 eligible hospitals.

(C) WRITTEN AGREEMENTS.—Eligible hospitals selected to participate in the demonstration shall enter into written agreements pursuant to subsection (b) in order to reimburse the eligible partners of the hospital the share of the costs attributable to each partner.

(2) COSTS DESCRIBED.—

(A) IN GENERAL.—Subject to subparagraph (B) and subsection (d), the costs described in this paragraph are the reasonable costs (as described in section 1861(v) of the Social Security Act (42 U.S.C. 1395x(v))) of each eligible hospital for the clinical training costs (as determined by the Secretary) that are attributable to providing advanced practice registered nurses with qualified training.

(B) LIMITATION.—With respect to a year, the amount reimbursed under subparagraph (A) may not exceed the amount of costs described in subparagraph (A) that are attributable to an increase in the number of advanced practice registered nurses enrolled in a program that provides qualified training during the year and for which the hospital is being reimbursed under the demonstration, as compared to the average number of advanced practice registered nurses who graduated in each year during the period beginning on January 1, 2006, and ending on December 31, 2010 (as determined by the Secretary) from the graduate nursing education program operated by the applicable school of nursing that is an eligible partner of the hospital for purposes of the demonstration.

(3) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act as may be necessary to carry out the demonstration.

(4) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to the implementation of this section.

(b) WRITTEN AGREEMENTS WITH ELIGIBLE PARTNERS.—No payment shall be made under this section to an eligible hospital unless such hospital has in effect a written agreement with the eligible partners of the hospital. Such written agreement shall describe, at a minimum—

(1) the obligations of the eligible partners with respect to the provision of qualified training; and

(2) the obligation of the eligible hospital to reimburse such eligible partners applicable (in a timely manner) for the costs of such qualified training attributable to partner.

(c) EVALUATION.—Not later than October 17, 2017, the Secretary shall submit to Congress a report on the demonstration. Such report shall include an analysis of the following:

(1) The growth in the number of advanced practice registered nurses with respect to a specific base year as a result of the demonstration.

(2) The growth for each of the specialties described in subparagraphs (A) through (D) of subsection (e)(1).

(3) The costs to the Medicare program under title XVIII of the Social Security Act as a result of the demonstration.

(4) Other items the Secretary determines appropriate and relevant.

(d) FUNDING.—

(1) IN GENERAL.—There is hereby appropriated to the Secretary, out of any funds in the Treasury not otherwise appropriated, $50,000,000 for each of fiscal years 2012 through 2015 to carry out this section, including the design, implementation, monitoring, and evaluation of the demonstration.

(2) PRORATION.—If the aggregate payments to eligible hospitals under the demonstration exceed $50,000,000 for a fiscal year described in paragraph (1), the Secretary shall prorate the payment amounts to each eligible hospital in order to ensure that the aggregate payments do not exceed such amount.

(3) WITHOUT FISCAL YEAR LIMITATION.—Amounts appropriated under this subsection shall remain available without fiscal year limitation.

(e) DEFINITIONS.—In this section:

(1) ADVANCED PRACTICE REGISTERED NURSE.—The term ''advanced practice registered nurse'' includes the following:

(A) A clinical nurse specialist (as defined in subsection (aa)(5) of section 1861 of the Social Security Act (42 U.S.C. 1395x)).

(B) A nurse practitioner (as defined in such subsection).

(C) A certified registered nurse anesthetist (as defined in subsection (bb)(2) of such section).

(D) A certified nurse-midwife (as defined in subsection (gg)(2) of such section).

(2) APPLICABLE NON-HOSPITAL COMMUNITY-BASED CARE SETTING.—The term ''applicable non-hospital community-based care setting'' means a non-hospital community-based care setting which has entered into a written agreement (as described in subsection (b)) with the eligible hospital participating in the demonstration. Such settings include Federally qualified health centers, rural health clinics, and other non-hospital settings as determined appropriate by the Secretary.

(3) APPLICABLE SCHOOL OF NURSING.—The term ''applicable school of nursing'' means an accredited school of nursing (as defined in section 801 of the Public Health Service Act) which has entered into a written agreement (as described in subsection

(b)) with the eligible hospital participating in the demonstration.

(4) DEMONSTRATION.—The term ''demonstration'' means the graduate nurse education demonstration established under subsection (a).

(5) ELIGIBLE HOSPITAL.—The term ''eligible hospital'' means a hospital (as defined in subsection (e) of section 1861 of the Social Security Act (42 U.S.C. 1395x)) or a critical access hospital (as defined in subsection (mm)(1) of such section) that has a written agreement in place with—

(A) 1 or more applicable schools of nursing; and

(B) 2 or more applicable non-hospital community-based care settings.

(6) ELIGIBLE PARTNERS.—The term ''eligible partners'' includes the following:

(A) An applicable non-hospital community-based care setting.

(B) An applicable school of nursing.

(7) QUALIFIED TRAINING.—

(A) IN GENERAL.—The term ''qualified training'' means training—

(i) that provides an advanced practice registered nurse with the clinical skills nec-

1 essary to provide primary care, preventive
2 care, transitional care, chronic care man-
3 agement, and other services appropriate
4 for individuals entitled to, or enrolled for,
5 benefits under part A of title XVIII of the
6 Social Security Act, or enrolled under part
7 B of such title; and
8 (ii) subject to subparagraph (B), at
9 least half of which is provided in a non-
10 hospital community-based care setting.
11 (B) WAIVER OF REQUIREMENT HALF OF
12 TRAINING BE PROVIDED IN NON-HOSPITAL
13 COMMUNITY-BASED CARE SETTING IN CERTAIN
14 AREAS.—The Secretary may waive the require-
15 ment under subparagraph (A)(ii) with respect
16 to eligible hospitals located in rural or medically
17 underserved areas.
18 (8) SECRETARY.—The term ''Secretary'' means
19 the Secretary of Health and Human Services.

Subtitle G—Improving Access to Health Care Services

SEC. 5601. SPENDING FOR FEDERALLY QUALIFIED HEALTH CENTERS (FQHCS).

(a) IN GENERAL.—Section 330(r) of the Public Health Service Act (42 U.S.C. 254b(r)) is amended by striking paragraph (1) and inserting the following:

"(1) GENERAL AMOUNTS FOR GRANTS.—For the purpose of carrying out this section, in addition to the amounts authorized to be appropriated under subsection (d), there is authorized to be appropriated the following:

"(A) For fiscal year 2010, $2,988,821,592.

"(B) For fiscal year 2011, $3,862,107,440.

"(C) For fiscal year 2012, $4,990,553,440.

"(D) For fiscal year 2013, $6,448,713,307.

"(E) For fiscal year 2014, $7,332,924,155.

"(F) For fiscal year 2015, $8,332,924,155.

"(G) For fiscal year 2016, and each subsequent fiscal year, the amount appropriated for

the preceding fiscal year adjusted by the product of—

"(i) one plus the average percentage increase in costs incurred per patient served; and

"(ii) one plus the average percentage increase in the total number of patients served.".

(b) RULE OF CONSTRUCTION.—Section 330(r) of the Public Health Service Act (42 U.S.C. 254b(r)) is amended by adding at the end the following:

"(4) RULE OF CONSTRUCTION WITH RESPECT TO RURAL HEALTH CLINICS.—

"(A) IN GENERAL.—Nothing in this section shall be construed to prevent a community health center from contracting with a Federally certified rural health clinic (as defined in section 1861(aa)(2) of the Social Security Act), a low-volume hospital (as defined for purposes of section 1886 of such Act), a critical access hospital, a sole community hospital (as defined for purposes of section 1886(d)(5)(D)(iii) of such Act), or a medicare-dependent share hospital (as defined for purposes of section 1886(d)(5)(G)(iv) of such Act) for the delivery

of primary health care services that are available at the clinic or hospital to individuals who would otherwise be eligible for free or reduced cost care if that individual were able to obtain that care at the community health center. Such services may be limited in scope to those primary health care services available in that clinic or hospitals.

"(B) ASSURANCES.—In order for a clinic or hospital to receive funds under this section through a contract with a community health center under subparagraph (A), such clinic or hospital shall establish policies to ensure—

"(i) nondiscrimination based on the ability of a patient to pay; and

"(ii) the establishment of a sliding fee scale for low-income patients.".

SEC. 5602. NEGOTIATED RULEMAKING FOR DEVELOPMENT OF METHODOLOGY AND CRITERIA FOR DESIGNATING MEDICALLY UNDERSERVED POPULATIONS AND HEALTH PROFESSIONS SHORTAGE AREAS.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the

"Secretary") shall establish, through a negotiated rulemaking process under subchapter 3 of chapter 5 of title 5, United States Code, a comprehensive methodology and criteria for designation of—

(A) medically underserved populations in accordance with section 330(b)(3) of the Public Health Service Act (42 U.S.C. 254b(b)(3));

(B) health professions shortage areas under section 332 of the Public Health Service Act (42 U.S.C. 254e).

(2) FACTORS TO CONSIDER.—In establishing the methodology and criteria under paragraph (1), the Secretary—

(A) shall consult with relevant stakeholders who will be significantly affected by a rule (such as national, State and regional organizations representing affected entities), State health offices, community organizations, health centers and other affected entities, and other interested parties; and

(B) shall take into account—

(i) the timely availability and appropriateness of data used to determine a designation to potential applicants for such designations;

(ii) the impact of the methodology and criteria on communities of various types and on health centers and other safety net providers;

(iii) the degree of ease or difficulty that will face potential applicants for such designations in securing the necessary data; and

(iv) the extent to which the methodology accurately measures various barriers that confront individuals and population groups in seeking health care services.

(b) PUBLICATION OF NOTICE.—In carrying out the rulemaking process under this subsection, the Secretary shall publish the notice provided for under section 564(a) of title 5, United States Code, by not later than 45 days after the date of the enactment of this Act.

(c) TARGET DATE FOR PUBLICATION OF RULE.—As part of the notice under subsection (b), and for purposes of this subsection, the ''target date for publication'', as referred to in section 564(a)(5) of title 5, United Sates Code, shall be July 1, 2010.

(d) APPOINTMENT OF NEGOTIATED RULEMAKING COMMITTEE AND FACILITATOR.—The Secretary shall provide for—

(1) the appointment of a negotiated rulemaking committee under section 565(a) of title 5, United States Code, by not later than 30 days after the end of the comment period provided for under section 564(c) of such title; and

(2) the nomination of a facilitator under section 566(c) of such title 5 by not later than 10 days after the date of appointment of the committee.

(e) PRELIMINARY COMMITTEE REPORT.—The negotiated rulemaking committee appointed under subsection (d) shall report to the Secretary, by not later than April 1, 2010, regarding the committee's progress on achieving a consensus with regard to the rulemaking proceeding and whether such consensus is likely to occur before one month before the target date for publication of the rule. If the committee reports that the committee has failed to make significant progress toward such consensus or is unlikely to reach such consensus by the target date, the Secretary may terminate such process and provide for the publication of a rule under this section through such other methods as the Secretary may provide.

(f) FINAL COMMITTEE REPORT.—If the committee is not terminated under subsection (e), the rulemaking committee shall submit a report containing a proposed

rule by not later than one month before the target publication date.

(g) INTERIM FINAL EFFECT.—The Secretary shall publish a rule under this section in the Federal Register by not later than the target publication date. Such rule shall be effective and final immediately on an interim basis, but is subject to change and revision after public notice and opportunity for a period (of not less than 90 days) for public comment. In connection with such rule, the Secretary shall specify the process for the timely review and approval of applications for such designations pursuant to such rules and consistent with this section.

(h) PUBLICATION OF RULE AFTER PUBLIC COMMENT.—The Secretary shall provide for consideration of such comments and republication of such rule by not later than 1 year after the target publication date.

SEC. 5603. REAUTHORIZATION OF THE WAKEFIELD EMERGENCY MEDICAL SERVICES FOR CHILDREN PROGRAM.

Section 1910 of the Public Health Service Act (42 U.S.C. 300w–9) is amended—

(1) in subsection (a), by striking ''3-year period (with an optional 4th year'' and inserting ''4-year period (with an optional 5th year''; and

(2) in subsection (d)—

(A) by striking ''and such sums'' and inserting ''such sums''; and

(B) by inserting before the period the following: '', $25,000,000 for fiscal year 2010, $26,250,000 for fiscal year 2011, $27,562,500 for fiscal year 2012, $28,940,625 for fiscal year 2013, and $30,387,656 for fiscal year 2014''.

SEC. 5604. CO-LOCATING PRIMARY AND SPECIALTY CARE IN COMMUNITY-BASED MENTAL HEALTH SETTINGS.

Subpart 3 of part B of title V of the Public Health Service Act (42 U.S.C. 290bb–31 et seq.) is amended by adding at the end the following:

''SEC. 520K. AWARDS FOR CO-LOCATING PRIMARY AND SPECIALTY CARE IN COMMUNITY-BASED MENTAL HEALTH SETTINGS.

''(a) DEFINITIONS.—In this section:

''(1) ELIGIBLE ENTITY.—The term 'eligible entity' means a qualified community mental health program defined under section 1913(b)(1).

''(2) SPECIAL POPULATIONS.—The term 'special populations' means adults with mental illnesses who have co-occurring primary care conditions and chronic diseases.

1 "(b) PROGRAM AUTHORIZED.—The Secretary, acting
2 through the Administrator shall award grants and cooper-
3 ative agreements to eligible entities to establish dem-
4 onstration projects for the provision of coordinated and
5 integrated services to special populations through the co-
6 location of primary and specialty care services in commu-
7 nity-based mental and behavioral health settings.

8 "(c) APPLICATION.—To be eligible to receive a grant
9 or cooperative agreement under this section, an eligible en-
10 tity shall submit an application to the Administrator at
11 such time, in such manner, and accompanied by such in-
12 formation as the Administrator may require, including a
13 description of partnerships, or other arrangements with
14 local primary care providers, including community health
15 centers, to provide services to special populations.

16 "(d) USE OF FUNDS.—

17 "(1) IN GENERAL.—For the benefit of special
18 populations, an eligible entity shall use funds award-
19 ed under this section for—

20 "(A) the provision, by qualified primary
21 care professionals, of on site primary care serv-
22 ices;

23 "(B) reasonable costs associated with
24 medically necessary referrals to qualified spe-
25 cialty care professionals, other coordinators of

1 care or, if permitted by the terms of the grant
2 or cooperative agreement, by qualified specialty
3 care professionals on a reasonable cost basis on
4 site at the eligible entity;
5 ''(C) information technology required to
6 accommodate the clinical needs of primary and
7 specialty care professionals; or
8 ''(D) facility modifications needed to bring
9 primary and specialty care professionals on site
10 at the eligible entity.
11 ''(2) LIMITATION.—Not to exceed 15 percent of
12 grant or cooperative agreement funds may be used
13 for activities described in subparagraphs (C) and
14 (D) of paragraph (1).
15 ''(e) EVALUATION.—Not later than 90 days after a
16 grant or cooperative agreement awarded under this section
17 expires, an eligible entity shall submit to the Secretary the
18 results of an evaluation to be conducted by the entity con-
19 cerning the effectiveness of the activities carried out under
20 the grant or agreement.
21 ''(f) AUTHORIZATION OF APPROPRIATIONS.—There
22 are authorized to be appropriated to carry out this section,
23 $50,000,000 for fiscal year 2010 and such sums as may
24 be necessary for each of fiscal years 2011 through 2014.''.

SEC. 5605. KEY NATIONAL INDICATORS.

(a) DEFINITIONS.—In this section:

(1) ACADEMY.—The term ''Academy'' means the National Academy of Sciences.

(2) COMMISSION.—The term ''Commission'' means the Commission on Key National Indicators established under subsection (b).

(3) INSTITUTE.—The term ''Institute'' means a Key National Indicators Institute as designated under subsection (c)(3).

(b) COMMISSION ON KEY NATIONAL INDICATORS.—

(1) ESTABLISHMENT.—There is established a ''Commission on Key National Indicators''.

(2) MEMBERSHIP.—

(A) NUMBER AND APPOINTMENT.—The Commission shall be composed of 8 members, to be appointed equally by the majority and minority leaders of the Senate and the Speaker and minority leader of the House of Representatives.

(B) PROHIBITED APPOINTMENTS.—Members of the Commission shall not include Members of Congress or other elected Federal, State, or local government officials.

(C) QUALIFICATIONS.—In making appointments under subparagraph (A), the majority

and minority leaders of the Senate and the Speaker and minority leader of the House of Representatives shall appoint individuals who have shown a dedication to improving civic dialogue and decision-making through the wide use of scientific evidence and factual information.

(D) PERIOD OF APPOINTMENT.—Each member of the Commission shall be appointed for a 2-year term, except that 1 initial appointment shall be for 3 years. Any vacancies shall not affect the power and duties of the Commission but shall be filled in the same manner as the original appointment and shall last only for the remainder of that term.

(E) DATE.—Members of the Commission shall be appointed by not later than 30 days after the date of enactment of this Act.

(F) INITIAL ORGANIZING PERIOD.——Not later than 60 days after the date of enactment of this Act, the Commission shall develop and implement a schedule for completion of the review and reports required under subsection (d).

(G) CO-CHAIRPERSONS.—The Commission shall select 2 Co-Chairpersons from among its members.

(c) DUTIES OF THE COMMISSION.—

(1) IN GENERAL.—The Commission shall—

(A) conduct comprehensive oversight of a newly established key national indicators system consistent with the purpose described in this subsection;

(B) make recommendations on how to improve the key national indicators system;

(C) coordinate with Federal Government users and information providers to assure access to relevant and quality data; and

(D) enter into contracts with the Academy.

(2) REPORTS.—

(A) ANNUAL REPORT TO CONGRESS.—Not later than 1 year after the selection of the 2 Co-Chairpersons of the Commission, and each subsequent year thereafter, the Commission shall prepare and submit to the appropriate Committees of Congress and the President a report that contains a detailed statement of the recommendations, findings, and conclusions of the Commission on the activities of the Academy and a designated Institute related to the establishment of a Key National Indicator System.

(B) ANNUAL REPORT TO THE ACADEMY.—

(i) IN GENERAL.—Not later than 6 months after the selection of the 2 Co-Chairpersons of the Commission, and each subsequent year thereafter, the Commission shall prepare and submit to the Academy and a designated Institute a report making recommendations concerning potential issue areas and key indicators to be included in the Key National Indicators.

(ii) LIMITATION.—The Commission shall not have the authority to direct the Academy or, if established, the Institute, to adopt, modify, or delete any key indicators.

(3) CONTRACT WITH THE NATIONAL ACADEMY OF SCIENCES.—

(A) IN GENERAL.——As soon as practicable after the selection of the 2 Co-Chairpersons of the Commission, the Co-Chairpersons shall enter into an arrangement with the National Academy of Sciences under which the Academy shall—

(i) review available public and private sector research on the selection of a set of key national indicators;

(ii) determine how best to establish a key national indicator system for the United States, by either creating its own institutional capability or designating an independent private nonprofit organization as an Institute to implement a key national indicator system;

(iii) if the Academy designates an independent Institute under clause (ii), provide scientific and technical advice to the Institute and create an appropriate governance mechanism that balances Academy involvement and the independence of the Institute; and

(iv) provide an annual report to the Commission addressing scientific and technical issues related to the key national indicator system and, if established, the Institute, and governance of the Institute's budget and operations.

(B) PARTICIPATION.—In executing the arrangement under subparagraph (A), the Na-

tional Academy of Sciences shall convene a multi-sector, multi-disciplinary process to define major scientific and technical issues associated with developing, maintaining, and evolving a Key National Indicator System and, if an Institute is established, to provide it with scientific and technical advice.

(C) ESTABLISHMENT OF A KEY NATIONAL INDICATOR SYSTEM.—

(i) IN GENERAL.—In executing the arrangement under subparagraph (A), the National Academy of Sciences shall enable the establishment of a key national indicator system by—

(I) creating its own institutional capability; or

(II) partnering with an independent private nonprofit organization as an Institute to implement a key national indicator system.

(ii) INSTITUTE.—If the Academy designates an Institute under clause (i)(II), such Institute shall be a non-profit entity (as defined for purposes of section 501(c)(3) of the Internal Revenue Code of

1986) with an educational mission, a governance structure that emphasizes independence, and characteristics that make such entity appropriate for establishing a key national indicator system.

(iii) RESPONSIBILITIES.—Either the Academy or the Institute designated under clause (i)(II) shall be responsible for the following:

(I) Identifying and selecting issue areas to be represented by the key national indicators.

(II) Identifying and selecting the measures used for key national indicators within the issue areas under subclause (I).

(III) Identifying and selecting data to populate the key national indicators described under subclause (II).

(IV) Designing, publishing, and maintaining a public website that contains a freely accessible database allowing public access to the key national indicators.

(V) Developing a quality assurance framework to ensure rigorous and independent processes and the selection of quality data.

(VI) Developing a budget for the construction and management of a sustainable, adaptable, and evolving key national indicator system that reflects all Commission funding of Academy and, if an Institute is established, Institute activities.

(VII) Reporting annually to the Commission regarding its selection of issue areas, key indicators, data, and progress toward establishing a web-accessible database.

(VIII) Responding directly to the Commission in response to any Commission recommendations and to the Academy regarding any inquiries by the Academy.

(iv) GOVERNANCE.—Upon the establishment of a key national indicator system, the Academy shall create an appropriate governance mechanism that incor-

porates advisory and control functions. If an Institute is designated under clause (i)(II), the governance mechanism shall balance appropriate Academy involvement and the independence of the Institute.

(v) MODIFICATION AND CHANGES.—The Academy shall retain the sole discretion, at any time, to alter its approach to the establishment of a key national indicator system or, if an Institute is designated under clause (i)(II), to alter any aspect of its relationship with the Institute or to designate a different non-profit entity to serve as the Institute.

(vi) CONSTRUCTION.—Nothing in this section shall be construed to limit the ability of the Academy or the Institute designated under clause (i)(II) to receive private funding for activities related to the establishment of a key national indicator system.

(D) ANNUAL REPORT.—As part of the arrangement under subparagraph (A), the National Academy of Sciences shall, not later than 270 days after the date of enactment of this

Act, and annually thereafter, submit to the Co-Chairpersons of the Commission a report that contains the findings and recommendations of the Academy.

(d) GOVERNMENT ACCOUNTABILITY OFFICE STUDY AND REPORT.—

(1) GAO STUDY.—The Comptroller General of the United States shall conduct a study of previous work conducted by all public agencies, private organizations, or foreign countries with respect to best practices for a key national indicator system. The study shall be submitted to the appropriate authorizing committees of Congress.

(2) GAO FINANCIAL AUDIT.—If an Institute is established under this section, the Comptroller General shall conduct an annual audit of the financial statements of the Institute, in accordance with generally accepted government auditing standards and submit a report on such audit to the Commission and the appropriate authorizing committees of Congress.

(3) GAO PROGRAMMATIC REVIEW.—The Comptroller General of the United States shall conduct programmatic assessments of the Institute established under this section as determined necessary by

the Comptroller General and report the findings to the Commission and to the appropriate authorizing committees of Congress.

(e) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.——There are authorized to be appropriated to carry out the purposes of this section, $10,000,000 for fiscal year 2010, and $7,500,000 for each of fiscal year 2011 through 2018.

(2) AVAILABILITY.——Amounts appropriated under paragraph (1) shall remain available until expended.

Subtitle H—General Provisions

SEC. 5701. REPORTS.

(a) REPORTS BY SECRETARY OF HEALTH AND HUMAN SERVICES.—On an annual basis, the Secretary of Health and Human Services shall submit to the appropriate Committees of Congress a report on the activities carried out under the amendments made by this title, and the effectiveness of such activities.

(b) REPORTS BY RECIPIENTS OF FUNDS.—The Secretary of Health and Human Services may require, as a condition of receiving funds under the amendments made by this title, that the entity receiving such award submit to such Secretary such reports as the such Secretary may

1 require on activities carried out with such award, and the
2 effectiveness of such activities.

3 TITLE VI—TRANSPARENCY AND 4 PROGRAM INTEGRITY

5 Subtitle A—Physician Ownership 6 and Other Transparency

7 SEC. 6001. LIMITATION ON MEDICARE EXCEPTION TO THE 8 PROHIBITION ON CERTAIN PHYSICIAN RE- 9 FERRALS FOR HOSPITALS.

10 (a) IN GENERAL.—Section 1877 of the Social Secu-
11 rity Act (42 U.S.C. 1395nn) is amended—
12 (1) in subsection (d)(2)—
13 (A) in subparagraph (A), by striking
14 ''and'' at the end;
15 (B) in subparagraph (B), by striking the
16 period at the end and inserting ''; and''; and
17 (C) by adding at the end the following new
18 subparagraph:
19 ''(C) in the case where the entity is a hos-
20 pital, the hospital meets the requirements of
21 paragraph (3)(D).'';
22 (2) in subsection (d)(3)—
23 (A) in subparagraph (B), by striking
24 ''and'' at the end;

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

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

"(D) the hospital meets the requirements described in subsection (i)(1) not later than 18 months after the date of the enactment of this subparagraph."; and

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

"(i) REQUIREMENTS FOR HOSPITALS TO QUALIFY FOR RURAL PROVIDER AND HOSPITAL EXCEPTION TO OWNERSHIP OR INVESTMENT PROHIBITION.—

"(1) REQUIREMENTS DESCRIBED.—For purposes of subsection (d)(3)(D), the requirements described in this paragraph for a hospital are as follows:

"(A) PROVIDER AGREEMENT.—The hospital had—

"(i) physician ownership or investment on February 1, 2010; and

"(ii) a provider agreement under section 1866 in effect on such date.

"(B) LIMITATION ON EXPANSION OF FACILITY CAPACITY.—Except as provided in para-

graph (3), the number of operating rooms, procedure rooms, and beds for which the hospital is licensed at any time on or after the date of the enactment of this subsection is no greater than the number of operating rooms, procedure rooms, and beds for which the hospital is licensed as of such date.

"(C) PREVENTING CONFLICTS OF INTEREST.—

"(i) The hospital submits to the Secretary an annual report containing a detailed description of—

"(I) the identity of each physician owner or investor and any other owners or investors of the hospital; and

"(II) the nature and extent of all ownership and investment interests in the hospital.

"(ii) The hospital has procedures in place to require that any referring physician owner or investor discloses to the patient being referred, by a time that permits the patient to make a meaningful decision

1 regarding the receipt of care, as deter-
2 mined by the Secretary—
3 "(I) the ownership or investment
4 interest, as applicable, of such refer-
5 ring physician in the hospital; and
6 "(II) if applicable, any such own-
7 ership or investment interest of the
8 treating physician.
9 "(iii) The hospital does not condition
10 any physician ownership or investment in-
11 terests either directly or indirectly on the
12 physician owner or investor making or in-
13 fluencing referrals to the hospital or other-
14 wise generating business for the hospital.
15 "(iv) The hospital discloses the fact
16 that the hospital is partially owned or in-
17 vested in by physicians—
18 "(I) on any public website for the
19 hospital; and
20 "(II) in any public advertising
21 for the hospital.
22 "(D) ENSURING BONA FIDE INVEST-
23 MENT.—
24 "(i) The percentage of the total value
25 of the ownership or investment interests

1 held in the hospital, or in an entity whose
2 assets include the hospital, by physician
3 owners or investors in the aggregate does
4 not exceed such percentage as of the date
5 of enactment of this subsection.

6 ''(ii) Any ownership or investment in-
7 terests that the hospital offers to a physi-
8 cian owner or investor are not offered on
9 more favorable terms than the terms of-
10 fered to a person who is not a physician
11 owner or investor.

12 ''(iii) The hospital (or any owner or
13 investor in the hospital) does not directly
14 or indirectly provide loans or financing for
15 any investment in the hospital by a physi-
16 cian owner or investor.

17 ''(iv) The hospital (or any owner or
18 investor in the hospital) does not directly
19 or indirectly guarantee a loan, make a pay-
20 ment toward a loan, or otherwise subsidize
21 a loan, for any individual physician owner
22 or investor or group of physician owners or
23 investors that is related to acquiring any
24 ownership or investment interest in the
25 hospital.

1 "(v) Ownership or investment returns
2 are distributed to each owner or investor in
3 the hospital in an amount that is directly
4 proportional to the ownership or invest-
5 ment interest of such owner or investor in
6 the hospital.
7 "(vi) Physician owners and investors
8 do not receive, directly or indirectly, any
9 guaranteed receipt of or right to purchase
10 other business interests related to the hos-
11 pital, including the purchase or lease of
12 any property under the control of other
13 owners or investors in the hospital or lo-
14 cated near the premises of the hospital.
15 "(vii) The hospital does not offer a
16 physician owner or investor the oppor-
17 tunity to purchase or lease any property
18 under the control of the hospital or any
19 other owner or investor in the hospital on
20 more favorable terms than the terms of-
21 fered to an individual who is not a physi-
22 cian owner or investor.
23 "(E) PATIENT SAFETY.—
24 "(i) Insofar as the hospital admits a
25 patient and does not have any physician

available on the premises to provide services during all hours in which the hospital is providing services to such patient, before admitting the patient—

"(I) the hospital discloses such fact to a patient; and

"(II) following such disclosure, the hospital receives from the patient a signed acknowledgment that the patient understands such fact.

"(ii) The hospital has the capacity to—

"(I) provide assessment and initial treatment for patients; and

"(II) refer and transfer patients to hospitals with the capability to treat the needs of the patient involved.

"(F) LIMITATION ON APPLICATION TO CERTAIN CONVERTED FACILITIES.—The hospital was not converted from an ambulatory surgical center to a hospital on or after the date of enactment of this subsection.

"(2) PUBLICATION OF INFORMATION REPORTED.—The Secretary shall publish, and update

on an annual basis, the information submitted by hospitals under paragraph (1)(C)(i) on the public Internet website of the Centers for Medicare & Medicaid Services.

"(3) EXCEPTION TO PROHIBITION ON EXPANSION OF FACILITY CAPACITY.—

"(A) PROCESS.—

"(i) ESTABLISHMENT.—The Secretary shall establish and implement a process under which an applicable hospital (as defined in subparagraph (E)) may apply for an exception from the requirement under paragraph (1)(B).

"(ii) OPPORTUNITY FOR COMMUNITY INPUT.—The process under clause (i) shall provide individuals and entities in the community in which the applicable hospital applying for an exception is located with the opportunity to provide input with respect to the application.

"(iii) TIMING FOR IMPLEMENTATION.—The Secretary shall implement the process under clause (i) on August 1, 2011.

"(iv) REGULATIONS.—Not later than July 1, 2011, the Secretary shall promulgate regulations to carry out the process under clause (i).

"(B) FREQUENCY.—The process described in subparagraph (A) shall permit an applicable hospital to apply for an exception up to once every 2 years.

"(C) PERMITTED INCREASE.—

"(i) IN GENERAL.—Subject to clause (ii) and subparagraph (D), an applicable hospital granted an exception under the process described in subparagraph (A) may increase the number of operating rooms, procedure rooms, and beds for which the applicable hospital is licensed above the baseline number of operating rooms, procedure rooms, and beds of the applicable hospital (or, if the applicable hospital has been granted a previous exception under this paragraph, above the number of operating rooms, procedure rooms, and beds for which the hospital is licensed after the application of the most recent increase under such an exception).

"(ii) 100 PERCENT INCREASE LIMITATION.—The Secretary shall not permit an increase in the number of operating rooms, procedure rooms, and beds for which an applicable hospital is licensed under clause (i) to the extent such increase would result in the number of operating rooms, procedure rooms, and beds for which the applicable hospital is licensed exceeding 200 percent of the baseline number of operating rooms, procedure rooms, and beds of the applicable hospital.

"(iii) BASELINE NUMBER OF OPERATING ROOMS, PROCEDURE ROOMS, AND BEDS.—In this paragraph, the term 'baseline number of operating rooms, procedure rooms, and beds' means the number of operating rooms, procedure rooms, and beds for which the applicable hospital is licensed as of the date of enactment of this subsection.

"(D) INCREASE LIMITED TO FACILITIES ON THE MAIN CAMPUS OF THE HOSPITAL.—Any increase in the number of operating rooms, procedure rooms, and beds for which an appli-

1 cable hospital is licensed pursuant to this para-
2 graph may only occur in facilities on the main
3 campus of the applicable hospital.

4 "(E) APPLICABLE HOSPITAL.—In this
5 paragraph, the term 'applicable hospital' means
6 a hospital—

7 "(i) that is located in a county in
8 which the percentage increase in the popu-
9 lation during the most recent 5-year period
10 (as of the date of the application under
11 subparagraph (A)) is at least 150 percent
12 of the percentage increase in the popu-
13 lation growth of the State in which the
14 hospital is located during that period, as
15 estimated by Bureau of the Census;

16 "(ii) whose annual percent of total in-
17 patient admissions that represent inpatient
18 admissions under the program under title
19 XIX is equal to or greater than the aver-
20 age percent with respect to such admis-
21 sions for all hospitals located in the county
22 in which the hospital is located;

23 "(iii) that does not discriminate
24 against beneficiaries of Federal health care
25 programs and does not permit physicians

practicing at the hospital to discriminate against such beneficiaries;

"(iv) that is located in a State in which the average bed capacity in the State is less than the national average bed capacity; and

"(v) that has an average bed occupancy rate that is greater than the average bed occupancy rate in the State in which the hospital is located.

"(F) PROCEDURE ROOMS.—In this subsection, the term 'procedure rooms' includes rooms in which catheterizations, angiographies, angiograms, and endoscopies are performed, except such term shall not include emergency rooms or departments (exclusive of rooms in which catheterizations, angiographies, angiograms, and endoscopies are performed).

"(G) PUBLICATION OF FINAL DECISIONS.—Not later than 60 days after receiving a complete application under this paragraph, the Secretary shall publish in the Federal Register the final decision with respect to such application.

"(H) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the process under this paragraph (including the establishment of such process).

"(4) COLLECTION OF OWNERSHIP AND INVESTMENT INFORMATION.—For purposes of subparagraphs (A)(i) and (D)(i) of paragraph (1), the Secretary shall collect physician ownership and investment information for each hospital.

"(5) PHYSICIAN OWNER OR INVESTOR DEFINED.—For purposes of this subsection, the term 'physician owner or investor' means a physician (or an immediate family member of such physician) with a direct or an indirect ownership or investment interest in the hospital.

"(6) CLARIFICATION.—Nothing in this subsection shall be construed as preventing the Secretary from revoking a hospital's provider agreement if not in compliance with regulations implementing section 1866.".

(b) ENFORCEMENT.—

(1) ENSURING COMPLIANCE.—The Secretary of Health and Human Services shall establish policies and procedures to ensure compliance with the re-

quirements described in subsection (i)(1) of section 1877 of the Social Security Act, as added by subsection (a)(3), beginning on the date such requirements first apply. Such policies and procedures may include unannounced site reviews of hospitals.

(2) AUDITS.—Beginning not later than November 1, 2011, the Secretary of Health and Human Services shall conduct audits to determine if hospitals violate the requirements referred to in paragraph (1).

SEC. 6002. TRANSPARENCY REPORTS AND REPORTING OF PHYSICIAN OWNERSHIP OR INVESTMENT INTERESTS.

Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by inserting after section 1128F the following new section:

"SEC. 1128G. TRANSPARENCY REPORTS AND REPORTING OF PHYSICIAN OWNERSHIP OR INVESTMENT INTERESTS.

"(a) TRANSPARENCY REPORTS.—

"(1) PAYMENTS OR OTHER TRANSFERS OF VALUE.—

"(A) IN GENERAL.—On March 31, 2013, and on the 90th day of each calendar year beginning thereafter, any applicable manufacturer

that provides a payment or other transfer of value to a covered recipient (or to an entity or individual at the request of or designated on behalf of a covered recipient), shall submit to the Secretary, in such electronic form as the Secretary shall require, the following information with respect to the preceding calendar year:

"(i) The name of the covered recipient.

"(ii) The business address of the covered recipient and, in the case of a covered recipient who is a physician, the specialty and National Provider Identifier of the covered recipient.

"(iii) The amount of the payment or other transfer of value.

"(iv) The dates on which the payment or other transfer of value was provided to the covered recipient.

"(v) A description of the form of the payment or other transfer of value, indicated (as appropriate for all that apply) as—

"(I) cash or a cash equivalent;

"(II) in-kind items or services;

"(III) stock, a stock option, or any other ownership interest, dividend, profit, or other return on investment; or

"(IV) any other form of payment or other transfer of value (as defined by the Secretary).

"(vi) A description of the nature of the payment or other transfer of value, indicated (as appropriate for all that apply) as—

"(I) consulting fees;

"(II) compensation for services other than consulting;

"(III) honoraria;

"(IV) gift;

"(V) entertainment;

"(VI) food;

"(VII) travel (including the specified destinations);

"(VIII) education;

"(IX) research;

"(X) charitable contribution;

"(XI) royalty or license;

1 "(XII) current or prospective
2 ownership or investment interest;
3 "(XIII) direct compensation for
4 serving as faculty or as a speaker for
5 a medical education program;
6 "(XIV) grant; or
7 "(XV) any other nature of the
8 payment or other transfer of value (as
9 defined by the Secretary).
10 "(vii) If the payment or other transfer
11 of value is related to marketing, education,
12 or research specific to a covered drug, de-
13 vice, biological, or medical supply, the
14 name of that covered drug, device, biologi-
15 cal, or medical supply.
16 "(viii) Any other categories of infor-
17 mation regarding the payment or other
18 transfer of value the Secretary determines
19 appropriate.
20 "(B) SPECIAL RULE FOR CERTAIN PAY-
21 MENTS OR OTHER TRANSFERS OF VALUE.—In
22 the case where an applicable manufacturer pro-
23 vides a payment or other transfer of value to an
24 entity or individual at the request of or des-
25 ignated on behalf of a covered recipient, the ap-

1 plicable manufacturer shall disclose that pay-
2 ment or other transfer of value under the name
3 of the covered recipient.

4 "(2) PHYSICIAN OWNERSHIP.—In addition to
5 the requirement under paragraph (1)(A), on March
6 31, 2013, and on the 90th day of each calendar year
7 beginning thereafter, any applicable manufacturer or
8 applicable group purchasing organization shall sub-
9 mit to the Secretary, in such electronic form as the
10 Secretary shall require, the following information re-
11 garding any ownership or investment interest (other
12 than an ownership or investment interest in a pub-
13 licly traded security and mutual fund, as described
14 in section 1877(c)) held by a physician (or an imme-
15 diate family member of such physician (as defined
16 for purposes of section 1877(a))) in the applicable
17 manufacturer or applicable group purchasing organi-
18 zation during the preceding year:

19 "(A) The dollar amount invested by each
20 physician holding such an ownership or invest-
21 ment interest.

22 "(B) The value and terms of each such
23 ownership or investment interest.

24 "(C) Any payment or other transfer of
25 value provided to a physician holding such an

ownership or investment interest (or to an entity or individual at the request of or designated on behalf of a physician holding such an ownership or investment interest), including the information described in clauses (i) through (viii) of paragraph (1)(A), except that in applying such clauses, 'physician' shall be substituted for 'covered recipient' each place it appears.

"(D) Any other information regarding the ownership or investment interest the Secretary determines appropriate.

"(b) PENALTIES FOR NONCOMPLIANCE.—

"(1) FAILURE TO REPORT.—

"(A) IN GENERAL.—Subject to subparagraph (B) except as provided in paragraph (2), any applicable manufacturer or applicable group purchasing organization that fails to submit information required under subsection (a) in a timely manner in accordance with rules or regulations promulgated to carry out such subsection, shall be subject to a civil money penalty of not less than $1,000, but not more than $10,000, for each payment or other transfer of value or ownership or investment interest not reported as required under such subsection.

Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.

"(B) LIMITATION.—The total amount of civil money penalties imposed under subparagraph (A) with respect to each annual submission of information under subsection (a) by an applicable manufacturer or applicable group purchasing organization shall not exceed $150,000.

"(2) KNOWING FAILURE TO REPORT.—

"(A) IN GENERAL.—Subject to subparagraph (B), any applicable manufacturer or applicable group purchasing organization that knowingly fails to submit information required under subsection (a) in a timely manner in accordance with rules or regulations promulgated to carry out such subsection, shall be subject to a civil money penalty of not less than $10,000, but not more than $100,000, for each payment or other transfer of value or ownership or investment interest not reported as required under such subsection. Such penalty shall be imposed and collected in the same manner as

civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.

"(B) LIMITATION.—The total amount of civil money penalties imposed under subparagraph (A) with respect to each annual submission of information under subsection (a) by an applicable manufacturer or applicable group purchasing organization shall not exceed $1,000,000.

"(3) USE OF FUNDS.—Funds collected by the Secretary as a result of the imposition of a civil money penalty under this subsection shall be used to carry out this section.

"(c) PROCEDURES FOR SUBMISSION OF INFORMATION AND PUBLIC AVAILABILITY.—

"(1) IN GENERAL.—

"(A) ESTABLISHMENT.—Not later than October 1, 2011, the Secretary shall establish procedures—

"(i) for applicable manufacturers and applicable group purchasing organizations to submit information to the Secretary under subsection (a); and

"(ii) for the Secretary to make such information submitted available to the public.

"(B) DEFINITION OF TERMS.—The procedures established under subparagraph (A) shall provide for the definition of terms (other than those terms defined in subsection (e)), as appropriate, for purposes of this section.

"(C) PUBLIC AVAILABILITY.—Except as provided in subparagraph (E), the procedures established under subparagraph (A)(ii) shall ensure that, not later than September 30, 2013, and on June 30 of each calendar year beginning thereafter, the information submitted under subsection (a) with respect to the preceding calendar year is made available through an Internet website that—

"(i) is searchable and is in a format that is clear and understandable;

"(ii) contains information that is presented by the name of the applicable manufacturer or applicable group purchasing organization, the name of the covered recipient, the business address of the covered recipient, the specialty of the covered re-

cipient, the value of the payment or other transfer of value, the date on which the payment or other transfer of value was provided to the covered recipient, the form of the payment or other transfer of value, indicated (as appropriate) under subsection (a)(1)(A)(v), the nature of the payment or other transfer of value, indicated (as appropriate) under subsection (a)(1)(A)(vi), and the name of the covered drug, device, biological, or medical supply, as applicable;

''(iii) contains information that is able to be easily aggregated and downloaded;

''(iv) contains a description of any enforcement actions taken to carry out this section, including any penalties imposed under subsection (b), during the preceding year;

''(v) contains background information on industry-physician relationships;

''(vi) in the case of information submitted with respect to a payment or other transfer of value described in subparagraph (E)(i), lists such information separately from the other information sub-

1 mitted under subsection (a) and designates
2 such separately listed information as fund-
3 ing for clinical research;
4 ''(vii) contains any other information
5 the Secretary determines would be helpful
6 to the average consumer;
7 ''(viii) does not contain the National
8 Provider Identifier of the covered recipient,
9 and
10 ''(ix) subject to subparagraph (D),
11 provides the applicable manufacturer, ap-
12 plicable group purchasing organization, or
13 covered recipient an opportunity to review
14 and submit corrections to the information
15 submitted with respect to the applicable
16 manufacturer, applicable group purchasing
17 organization, or covered recipient, respec-
18 tively, for a period of not less than 45 days
19 prior to such information being made
20 available to the public.
21 ''(D) CLARIFICATION OF TIME PERIOD FOR
22 REVIEW AND CORRECTIONS.—In no case may
23 the 45-day period for review and submission of
24 corrections to information under subparagraph
25 (C)(ix) prevent such information from being

made available to the public in accordance with the dates described in the matter preceding clause (i) in subparagraph (C).

"(E) DELAYED PUBLICATION FOR PAYMENTS MADE PURSUANT TO PRODUCT RESEARCH OR DEVELOPMENT AGREEMENTS AND CLINICAL INVESTIGATIONS.—

"(i) IN GENERAL.—In the case of information submitted under subsection (a) with respect to a payment or other transfer of value made to a covered recipient by an applicable manufacturer pursuant to a product research or development agreement for services furnished in connection with research on a potential new medical technology or a new application of an existing medical technology or the development of a new drug, device, biological, or medical supply, or by an applicable manufacturer in connection with a clinical investigation regarding a new drug, device, biological, or medical supply, the procedures established under subparagraph (A)(ii) shall provide that such information is made available to the public on the first

date described in the matter preceding clause (i) in subparagraph (C) after the earlier of the following:

"(I) The date of the approval or clearance of the covered drug, device, biological, or medical supply by the Food and Drug Administration.

"(II) Four calendar years after the date such payment or other transfer of value was made.

"(ii) CONFIDENTIALITY OF INFORMATION PRIOR TO PUBLICATION.—Information described in clause (i) shall be considered confidential and shall not be subject to disclosure under section 552 of title 5, United States Code, or any other similar Federal, State, or local law, until on or after the date on which the information is made available to the public under such clause.

"(2) CONSULTATION.—In establishing the procedures under paragraph (1), the Secretary shall consult with the Inspector General of the Department of Health and Human Services, affected industry, consumers, consumer advocates, and other inter-

ested parties in order to ensure that the information made available to the public under such paragraph is presented in the appropriate overall context.

"(d) ANNUAL REPORTS AND RELATION TO STATE LAWS.—

"(1) ANNUAL REPORT TO CONGRESS.—Not later than April 1 of each year beginning with 2013, the Secretary shall submit to Congress a report that includes the following:

"(A) The information submitted under subsection (a) during the preceding year, aggregated for each applicable manufacturer and applicable group purchasing organization that submitted such information during such year (except, in the case of information submitted with respect to a payment or other transfer of value described in subsection (c)(1)(E)(i), such information shall be included in the first report submitted to Congress after the date on which such information is made available to the public under such subsection).

"(B) A description of any enforcement actions taken to carry out this section, including any penalties imposed under subsection (b), during the preceding year.

"(2) ANNUAL REPORTS TO STATES.—Not later than September 30, 2013 and on June 30 of each calendar year thereafter, the Secretary shall submit to States a report that includes a summary of the information submitted under subsection (a) during the preceding year with respect to covered recipients in the State (except, in the case of information submitted with respect to a payment or other transfer of value described in subsection (c)(1)(E)(i), such information shall be included in the first report submitted to States after the date on which such information is made available to the public under such subsection).

"(3) RELATION TO STATE LAWS.—

"(A) IN GENERAL.—In the case of a payment or other transfer of value provided by an applicable manufacturer that is received by a covered recipient (as defined in subsection (e)) on or after January 1, 2012, subject to subparagraph (B), the provisions of this section shall preempt any statute or regulation of a State or of a political subdivision of a State that requires an applicable manufacturer (as so defined) to disclose or report, in any format, the type of information (as described in sub-

1 section (a)) regarding such payment or other
2 transfer of value.
3 "(B) NO PREEMPTION OF ADDITIONAL RE-
4 QUIREMENTS.—Subparagraph (A) shall not
5 preempt any statute or regulation of a State or
6 of a political subdivision of a State that re-
7 quires the disclosure or reporting of informa-
8 tion—
9 "(i) not of the type required to be dis-
10 closed or reported under this section;
11 "(ii) described in subsection
12 (e)(10)(B), except in the case of informa-
13 tion described in clause (i) of such sub-
14 section;
15 "(iii) by any person or entity other
16 than an applicable manufacturer (as so de-
17 fined) or a covered recipient (as defined in
18 subsection (e)); or
19 "(iv) to a Federal, State, or local gov-
20 ernmental agency for public health surveil-
21 lance, investigation, or other public health
22 purposes or health oversight purposes.
23 "(C) Nothing in subparagraph (A) shall be
24 construed to limit the discovery or admissibility
25 of information described in such subparagraph

in a criminal, civil, or administrative proceeding.

"(4) CONSULTATION.—The Secretary shall consult with the Inspector General of the Department of Health and Human Services on the implementation of this section.

"(e) DEFINITIONS.—In this section:

"(1) APPLICABLE GROUP PURCHASING ORGANIZATION.—The term 'applicable group purchasing organization' means a group purchasing organization (as defined by the Secretary) that purchases, arranges for, or negotiates the purchase of a covered drug, device, biological, or medical supply which is operating in the United States, or in a territory, possession, or commonwealth of the United States.

"(2) APPLICABLE MANUFACTURER.—The term 'applicable manufacturer' means a manufacturer of a covered drug, device, biological, or medical supply which is operating in the United States, or in a territory, possession, or commonwealth of the United States.

"(3) CLINICAL INVESTIGATION.—The term 'clinical investigation' means any experiment involving 1 or more human subjects, or materials derived

from human subjects, in which a drug or device is administered, dispensed, or used.

"(4) COVERED DEVICE.—The term 'covered device' means any device for which payment is available under title XVIII or a State plan under title XIX or XXI (or a waiver of such a plan).

"(5) COVERED DRUG, DEVICE, BIOLOGICAL, OR MEDICAL SUPPLY.—The term 'covered drug, device, biological, or medical supply' means any drug, biological product, device, or medical supply for which payment is available under title XVIII or a State plan under title XIX or XXI (or a waiver of such a plan).

"(6) COVERED RECIPIENT.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), the term 'covered recipient' means the following:

"(i) A physician.

"(ii) A teaching hospital.

"(B) EXCLUSION.—Such term does not include a physician who is an employee of the applicable manufacturer that is required to submit information under subsection (a).

"(7) EMPLOYEE.—The term 'employee' has the meaning given such term in section 1877(h)(2).

1 "(8) KNOWINGLY.—The term 'knowingly' has
2 the meaning given such term in section 3729(b) of
3 title 31, United States Code.

4 "(9) MANUFACTURER OF A COVERED DRUG,
5 DEVICE, BIOLOGICAL, OR MEDICAL SUPPLY.—The
6 term 'manufacturer of a covered drug, device, bio-
7 logical, or medical supply' means any entity which is
8 engaged in the production, preparation, propagation,
9 compounding, or conversion of a covered drug, de-
10 vice, biological, or medical supply (or any entity
11 under common ownership with such entity which
12 provides assistance or support to such entity with re-
13 spect to the production, preparation, propagation,
14 compounding, conversion, marketing, promotion,
15 sale, or distribution of a covered drug, device, bio-
16 logical, or medical supply).

17 "(10) PAYMENT OR OTHER TRANSFER OF
18 VALUE.—

19 "(A) IN GENERAL.—The term 'payment or
20 other transfer of value' means a transfer of
21 anything of value. Such term does not include
22 a transfer of anything of value that is made in-
23 directly to a covered recipient through a third
24 party in connection with an activity or service
25 in the case where the applicable manufacturer

is unaware of the identity of the covered recipient.

"(B) EXCLUSIONS.—An applicable manufacturer shall not be required to submit information under subsection (a) with respect to the following:

"(i) A transfer of anything the value of which is less than $10, unless the aggregate amount transferred to, requested by, or designated on behalf of the covered recipient by the applicable manufacturer during the calendar year exceeds $100. For calendar years after 2012, the dollar amounts specified in the preceding sentence shall be increased by the same percentage as the percentage increase in the consumer price index for all urban consumers (all items; U.S. city average) for the 12-month period ending with June of the previous year.

"(ii) Product samples that are not intended to be sold and are intended for patient use.

"(iii) Educational materials that directly benefit patients or are intended for patient use.

"(iv) The loan of a covered device for a short-term trial period, not to exceed 90 days, to permit evaluation of the covered device by the covered recipient.

"(v) Items or services provided under a contractual warranty, including the replacement of a covered device, where the terms of the warranty are set forth in the purchase or lease agreement for the covered device.

"(vi) A transfer of anything of value to a covered recipient when the covered recipient is a patient and not acting in the professional capacity of a covered recipient.

"(vii) Discounts (including rebates).

"(viii) In-kind items used for the provision of charity care.

"(ix) A dividend or other profit distribution from, or ownership or investment interest in, a publicly traded security and mutual fund (as described in section 1877(c)).

1 "(x) In the case of an applicable man-
2 ufacturer who offers a self-insured plan,
3 payments for the provision of health care
4 to employees under the plan.
5 "(xi) In the case of a covered recipi-
6 ent who is a licensed non-medical profes-
7 sional, a transfer of anything of value to
8 the covered recipient if the transfer is pay-
9 ment solely for the non-medical profes-
10 sional services of such licensed non-medical
11 professional.
12 "(xii) In the case of a covered recipi-
13 ent who is a physician, a transfer of any-
14 thing of value to the covered recipient if
15 the transfer is payment solely for the serv-
16 ices of the covered recipient with respect to
17 a civil or criminal action or an administra-
18 tive proceeding.
19 "(11) PHYSICIAN.—The term 'physician' has
20 the meaning given that term in section 1861(r).".

SEC. 6003. DISCLOSURE REQUIREMENTS FOR IN-OFFICE ANCILLARY SERVICES EXCEPTION TO THE PROHIBITION ON PHYSICIAN SELF-REFERRAL FOR CERTAIN IMAGING SERVICES.

(a) IN GENERAL.—Section 1877(b)(2) of the Social Security Act (42 U.S.C. 1395nn(b)(2)) is amended by adding at the end the following new sentence: ''Such requirements shall, with respect to magnetic resonance imaging, computed tomography, positron emission tomography, and any other designated health services specified under subsection (h)(6)(D) that the Secretary determines appropriate, include a requirement that the referring physician inform the individual in writing at the time of the referral that the individual may obtain the services for which the individual is being referred from a person other than a person described in subparagraph (A)(i) and provide such individual with a written list of suppliers (as defined in section 1861(d)) who furnish such services in the area in which such individual resides.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to services furnished on or after January 1, 2010.

SEC. 6004. PRESCRIPTION DRUG SAMPLE TRANSPARENCY.

Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.), as amended by section 6002, is

amended by inserting after section 1128G the following new section:

"SEC. 1128H. REPORTING OF INFORMATION RELATING TO DRUG SAMPLES.

"(a) IN GENERAL.—Not later than April 1 of each year (beginning with 2012), each manufacturer and authorized distributor of record of an applicable drug shall submit to the Secretary (in a form and manner specified by the Secretary) the following information with respect to the preceding year:

"(1) In the case of a manufacturer or authorized distributor of record which makes distributions by mail or common carrier under subsection (d)(2) of section 503 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 353), the identity and quantity of drug samples requested and the identity and quantity of drug samples distributed under such subsection during that year, aggregated by—

"(A) the name, address, professional designation, and signature of the practitioner making the request under subparagraph (A)(i) of such subsection, or of any individual who makes or signs for the request on behalf of the practitioner; and

"(B) any other category of information determined appropriate by the Secretary.

"(2) In the case of a manufacturer or authorized distributor of record which makes distributions by means other than mail or common carrier under subsection (d)(3) of such section 503, the identity and quantity of drug samples requested and the identity and quantity of drug samples distributed under such subsection during that year, aggregated by—

"(A) the name, address, professional designation, and signature of the practitioner making the request under subparagraph (A)(i) of such subsection, or of any individual who makes or signs for the request on behalf of the practitioner; and

"(B) any other category of information determined appropriate by the Secretary.

"(b) DEFINITIONS.—In this section:

"(1) APPLICABLE DRUG.—The term 'applicable drug' means a drug—

"(A) which is subject to subsection (b) of such section 503; and

"(B) for which payment is available under title XVIII or a State plan under title XIX or XXI (or a waiver of such a plan).

"(2) AUTHORIZED DISTRIBUTOR OF RECORD.—The term 'authorized distributor of record' has the meaning given that term in subsection (e)(3)(A) of such section.

"(3) MANUFACTURER.—The term 'manufacturer' has the meaning given that term for purposes of subsection (d) of such section.".

SEC. 6005. PHARMACY BENEFIT MANAGERS TRANSPARENCY REQUIREMENTS.

Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by inserting after section 1150 the following new section:

"SEC. 1150A. PHARMACY BENEFIT MANAGERS TRANSPARENCY REQUIREMENTS.

"(a) PROVISION OF INFORMATION.—A health benefits plan or any entity that provides pharmacy benefits management services on behalf of a health benefits plan (in this section referred to as a 'PBM') that manages prescription drug coverage under a contract with—

"(1) a PDP sponsor of a prescription drug plan or an MA organization offering an MA–PD plan under part D of title XVIII; or

1 "(2) a qualified health benefits plan offered
2 through an exchange established by a State under
3 section 1311 of the Patient Protection and Afford-
4 able Care Act,
5 shall provide the information described in subsection (b)
6 to the Secretary and, in the case of a PBM, to the plan
7 with which the PBM is under contract with, at such times,
8 and in such form and manner, as the Secretary shall speci-
9 fy.
10 "(b) INFORMATION DESCRIBED.—The information
11 described in this subsection is the following with respect
12 to services provided by a health benefits plan or PBM for
13 a contract year:
14 "(1) The percentage of all prescriptions that
15 were provided through retail pharmacies compared
16 to mail order pharmacies, and the percentage of pre-
17 scriptions for which a generic drug was available and
18 dispensed (generic dispensing rate), by pharmacy
19 type (which includes an independent pharmacy,
20 chain pharmacy, supermarket pharmacy, or mass
21 merchandiser pharmacy that is licensed as a phar-
22 macy by the State and that dispenses medication to
23 the general public), that is paid by the health bene-
24 fits plan or PBM under the contract.

1 "(2) The aggregate amount, and the type of re-
2 bates, discounts, or price concessions (excluding
3 bona fide service fees, which include but are not lim-
4 ited to distribution service fees, inventory manage-
5 ment fees, product stocking allowances, and fees as-
6 sociated with administrative services agreements and
7 patient care programs (such as medication compli-
8 ance programs and patient education programs))that
9 the PBM negotiates that are attributable to patient
10 utilization under the plan, and the aggregate amount
11 of the rebates, discounts, or price concessions that
12 are passed through to the plan sponsor, and the
13 total number of prescriptions that were dispensed.
14 "(3) The aggregate amount of the difference
15 between the amount the health benefits plan pays
16 the PBM and the amount that the PBM pays retail
17 pharmacies, and mail order pharmacies, and the
18 total number of prescriptions that were dispensed.
19 "(c) CONFIDENTIALITY.—Information disclosed by a
20 health benefits plan or PBM under this section is con-
21 fidential and shall not be disclosed by the Secretary or
22 by a plan receiving the information, except that the Sec-
23 retary may disclose the information in a form which does
24 not disclose the identity of a specific PBM, plan, or prices
25 charged for drugs, for the following purposes:

"(1) As the Secretary determines to be necessary to carry out this section or part D of title XVIII.

"(2) To permit the Comptroller General to review the information provided.

"(3) To permit the Director of the Congressional Budget Office to review the information provided.

"(4) To States to carry out section 1311 of the Patient Protection and Affordable Care Act.

"(d) PENALTIES.—The provisions of subsection (b)(3)(C) of section 1927 shall apply to a health benefits plan or PBM that fails to provide information required under subsection (a) on a timely basis or that knowingly provides false information in the same manner as such provisions apply to a manufacturer with an agreement under that section.".

Subtitle B—Nursing Home Transparency and Improvement

PART I—IMPROVING TRANSPARENCY OF INFORMATION

SEC. 6101. REQUIRED DISCLOSURE OF OWNERSHIP AND ADDITIONAL DISCLOSABLE PARTIES INFORMATION.

(a) IN GENERAL.—Section 1124 of the Social Security Act (42 U.S.C. 1320a–3) is amended by adding at the end the following new subsection:

"(c) REQUIRED DISCLOSURE OF OWNERSHIP AND ADDITIONAL DISCLOSABLE PARTIES INFORMATION.—

"(1) DISCLOSURE.—A facility shall have the information described in paragraph (2) available—

"(A) during the period beginning on the date of the enactment of this subsection and ending on the date such information is made available to the public under section 6101(b) of the Patient Protection and Affordable Care Act for submission to the Secretary, the Inspector General of the Department of Health and Human Services, the State in which the facility is located, and the State long-term care ombudsman in the case where the Secretary, the Inspector General, the State, or the State long-

term care ombudsman requests such information; and

"(B) beginning on the effective date of the final regulations promulgated under paragraph (3)(A), for reporting such information in accordance with such final regulations.

Nothing in subparagraph (A) shall be construed as authorizing a facility to dispose of or delete information described in such subparagraph after the effective date of the final regulations promulgated under paragraph (3)(A).

"(2) INFORMATION DESCRIBED.—

"(A) IN GENERAL.—The following information is described in this paragraph:

"(i) The information described in subsections (a) and (b), subject to subparagraph (C).

"(ii) The identity of and information on—

"(I) each member of the governing body of the facility, including the name, title, and period of service of each such member;

"(II) each person or entity who is an officer, director, member, partner,

trustee, or managing employee of the facility, including the name, title, and period of service of each such person or entity; and

"(III) each person or entity who is an additional disclosable party of the facility.

"(iii) The organizational structure of each additional disclosable party of the facility and a description of the relationship of each such additional disclosable party to the facility and to one another.

"(B) SPECIAL RULE WHERE INFORMATION IS ALREADY REPORTED OR SUBMITTED.—To the extent that information reported by a facility to the Internal Revenue Service on Form 990, information submitted by a facility to the Securities and Exchange Commission, or information otherwise submitted to the Secretary or any other Federal agency contains the information described in clauses (i), (ii), or (iii) of subparagraph (A), the facility may provide such Form or such information submitted to meet the requirements of paragraph (1).

"(C) SPECIAL RULE.—In applying subparagraph (A)(i)—

"(i) with respect to subsections (a) and (b), 'ownership or control interest' shall include direct or indirect interests, including such interests in intermediate entities; and

"(ii) subsection (a)(3)(A)(ii) shall include the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured, in whole or in part, by the entity or any of the property or assets thereof, if the interest is equal to or exceeds 5 percent of the total property or assets of the entirety.

"(3) REPORTING.—

"(A) IN GENERAL.—Not later than the date that is 2 years after the date of the enactment of this subsection, the Secretary shall promulgate final regulations requiring, effective on the date that is 90 days after the date on which such final regulations are published in the Federal Register, a facility to report the information described in paragraph (2) to the Secretary in a standardized format, and such other regu-

lations as are necessary to carry out this subsection. Such final regulations shall ensure that the facility certifies, as a condition of participation and payment under the program under title XVIII or XIX, that the information reported by the facility in accordance with such final regulations is, to the best of the facility's knowledge, accurate and current.

"(B) GUIDANCE.—The Secretary shall provide guidance and technical assistance to States on how to adopt the standardized format under subparagraph (A).

"(4) NO EFFECT ON EXISTING REPORTING REQUIREMENTS.—Nothing in this subsection shall reduce, diminish, or alter any reporting requirement for a facility that is in effect as of the date of the enactment of this subsection.

"(5) DEFINITIONS.—In this subsection:

"(A) ADDITIONAL DISCLOSABLE PARTY.—The term 'additional disclosable party' means, with respect to a facility, any person or entity who—

"(i) exercises operational, financial, or managerial control over the facility or a part thereof, or provides policies or proce-

dures for any of the operations of the facility, or provides financial or cash management services to the facility;

"(ii) leases or subleases real property to the facility, or owns a whole or part interest equal to or exceeding 5 percent of the total value of such real property; or

"(iii) provides management or administrative services, management or clinical consulting services, or accounting or financial services to the facility.

"(B) FACILITY.—The term 'facility' means a disclosing entity which is—

"(i) a skilled nursing facility (as defined in section 1819(a)); or

"(ii) a nursing facility (as defined in section 1919(a)).

"(C) MANAGING EMPLOYEE.—The term 'managing employee' means, with respect to a facility, an individual (including a general manager, business manager, administrator, director, or consultant) who directly or indirectly manages, advises, or supervises any element of the practices, finances, or operations of the facility.

1 "(D) ORGANIZATIONAL STRUCTURE.—The
2 term 'organizational structure' means, in the
3 case of—
4 "(i) a corporation, the officers, direc-
5 tors, and shareholders of the corporation
6 who have an ownership interest in the cor-
7 poration which is equal to or exceeds 5
8 percent;
9 "(ii) a limited liability company, the
10 members and managers of the limited li-
11 ability company (including, as applicable,
12 what percentage each member and man-
13 ager has of the ownership interest in the
14 limited liability company);
15 "(iii) a general partnership, the part-
16 ners of the general partnership;
17 "(iv) a limited partnership, the gen-
18 eral partners and any limited partners of
19 the limited partnership who have an own-
20 ership interest in the limited partnership
21 which is equal to or exceeds 10 percent;
22 "(v) a trust, the trustees of the trust;
23 "(vi) an individual, contact informa-
24 tion for the individual; and

"(vii) any other person or entity, such information as the Secretary determines appropriate.".

(b) PUBLIC AVAILABILITY OF INFORMATION.—Not later than the date that is 1 year after the date on which the final regulations promulgated under section 1124(c)(3)(A) of the Social Security Act, as added by subsection (a), are published in the Federal Register, the Secretary of Health and Human Services shall make the information reported in accordance with such final regulations available to the public in accordance with procedures established by the Secretary.

(c) CONFORMING AMENDMENTS.—

(1) IN GENERAL.—

(A) SKILLED NURSING FACILITIES.—Section 1819(d)(1) of the Social Security Act (42 U.S.C. 1395i–3(d)(1)) is amended by striking subparagraph (B) and redesignating subparagraph (C) as subparagraph (B).

(B) NURSING FACILITIES.—Section 1919(d)(1) of the Social Security Act (42 U.S.C. 1396r(d)(1)) is amended by striking subparagraph (B) and redesignating subparagraph (C) as subparagraph (B).

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall take effect on the date on which the Secretary makes the information described in subsection (b)(1) available to the public under such subsection.

SEC. 6102. ACCOUNTABILITY REQUIREMENTS FOR SKILLED NURSING FACILITIES AND NURSING FACILITIES.

Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.), as amended by sections 6002 and 6004, is amended by inserting after section 1128H the following new section:

"SEC. 1128I. ACCOUNTABILITY REQUIREMENTS FOR FACILITIES.

"(a) DEFINITION OF FACILITY.—In this section, the term 'facility' means—

"(1) a skilled nursing facility (as defined in section 1819(a)); or

"(2) a nursing facility (as defined in section 1919(a)).

"(b) EFFECTIVE COMPLIANCE AND ETHICS PROGRAMS.—

"(1) REQUIREMENT.—On or after the date that is 36 months after the date of the enactment of this section, a facility shall, with respect to the entity

that operates the facility (in this subparagraph referred to as the 'operating organization' or 'organization'), have in operation a compliance and ethics program that is effective in preventing and detecting criminal, civil, and administrative violations under this Act and in promoting quality of care consistent with regulations developed under paragraph (2).

"(2) DEVELOPMENT OF REGULATIONS.—

"(A) IN GENERAL.—Not later than the date that is 2 years after such date of the enactment, the Secretary, working jointly with the Inspector General of the Department of Health and Human Services, shall promulgate regulations for an effective compliance and ethics program for operating organizations, which may include a model compliance program.

"(B) DESIGN OF REGULATIONS.—Such regulations with respect to specific elements or formality of a program shall, in the case of an organization that operates 5 or more facilities, vary with the size of the organization, such that larger organizations should have a more formal program and include established written policies defining the standards and procedures to be followed by its employees. Such requirements may

1 specifically apply to the corporate level manage-
2 ment of multi unit nursing home chains.
3 "(C) EVALUATION.—Not later than 3
4 years after the date of the promulgation of reg-
5 ulations under this paragraph, the Secretary
6 shall complete an evaluation of the compliance
7 and ethics programs required to be established
8 under this subsection. Such evaluation shall de-
9 termine if such programs led to changes in defi-
10 ciency citations, changes in quality perform-
11 ance, or changes in other metrics of patient
12 quality of care. The Secretary shall submit to
13 Congress a report on such evaluation and shall
14 include in such report such recommendations
15 regarding changes in the requirements for such
16 programs as the Secretary determines appro-
17 priate.
18 "(3) REQUIREMENTS FOR COMPLIANCE AND
19 ETHICS PROGRAMS.—In this subsection, the term
20 'compliance and ethics program' means, with respect
21 to a facility, a program of the operating organization
22 that—
23 "(A) has been reasonably designed, imple-
24 mented, and enforced so that it generally will be
25 effective in preventing and detecting criminal,

civil, and administrative violations under this Act and in promoting quality of care; and

"(B) includes at least the required components specified in paragraph (4).

"(4) REQUIRED COMPONENTS OF PROGRAM.—The required components of a compliance and ethics program of an operating organization are the following:

"(A) The organization must have established compliance standards and procedures to be followed by its employees and other agents that are reasonably capable of reducing the prospect of criminal, civil, and administrative violations under this Act.

"(B) Specific individuals within high-level personnel of the organization must have been assigned overall responsibility to oversee compliance with such standards and procedures and have sufficient resources and authority to assure such compliance.

"(C) The organization must have used due care not to delegate substantial discretionary authority to individuals whom the organization knew, or should have known through the exercise of due diligence, had a propensity to en-

gage in criminal, civil, and administrative violations under this Act.

"(D) The organization must have taken steps to communicate effectively its standards and procedures to all employees and other agents, such as by requiring participation in training programs or by disseminating publications that explain in a practical manner what is required.

"(E) The organization must have taken reasonable steps to achieve compliance with its standards, such as by utilizing monitoring and auditing systems reasonably designed to detect criminal, civil, and administrative violations under this Act by its employees and other agents and by having in place and publicizing a reporting system whereby employees and other agents could report violations by others within the organization without fear of retribution.

"(F) The standards must have been consistently enforced through appropriate disciplinary mechanisms, including, as appropriate, discipline of individuals responsible for the failure to detect an offense.

"(G) After an offense has been detected, the organization must have taken all reasonable steps to respond appropriately to the offense and to prevent further similar offenses, including any necessary modification to its program to prevent and detect criminal, civil, and administrative violations under this Act.

"(H) The organization must periodically undertake reassessment of its compliance program to identify changes necessary to reflect changes within the organization and its facilities.

"(c) QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT PROGRAM.—

"(1) IN GENERAL.—Not later than December 31, 2011, the Secretary shall establish and implement a quality assurance and performance improvement program (in this subparagraph referred to as the 'QAPI program') for facilities, including multi unit chains of facilities. Under the QAPI program, the Secretary shall establish standards relating to quality assurance and performance improvement with respect to facilities and provide technical assistance to facilities on the development of best practices in order to meet such standards. Not later than

1 year after the date on which the regulations are promulgated under paragraph (2), a facility must submit to the Secretary a plan for the facility to meet such standards and implement such best practices, including how to coordinate the implementation of such plan with quality assessment and assurance activities conducted under sections 1819(b)(1)(B) and 1919(b)(1)(B), as applicable.

"(2) REGULATIONS.—The Secretary shall promulgate regulations to carry out this subsection.".

SEC. 6103. NURSING HOME COMPARE MEDICARE WEBSITE.

(a) SKILLED NURSING FACILITIES.—

(1) IN GENERAL.—Section 1819 of the Social Security Act (42 U.S.C. 1395i–3) is amended—

(A) by redesignating subsection (i) as subsection (j); and

(B) by inserting after subsection (h) the following new subsection:

"(i) NURSING HOME COMPARE WEBSITE.—

"(1) INCLUSION OF ADDITIONAL INFORMATION.—

"(A) IN GENERAL.—The Secretary shall ensure that the Department of Health and Human Services includes, as part of the information provided for comparison of nursing

1 homes on the official Internet website of the
2 Federal Government for Medicare beneficiaries
3 (commonly referred to as the 'Nursing Home
4 Compare' Medicare website) (or a successor
5 website), the following information in a manner
6 that is prominent, updated on a timely basis,
7 easily accessible, readily understandable to con-
8 sumers of long-term care services, and search-
9 able:

10 "(i) Staffing data for each facility (in-
11 cluding resident census data and data on
12 the hours of care provided per resident per
13 day) based on data submitted under sec-
14 tion 1128I(g), including information on
15 staffing turnover and tenure, in a format
16 that is clearly understandable to con-
17 sumers of long-term care services and al-
18 lows such consumers to compare dif-
19 ferences in staffing between facilities and
20 State and national averages for the facili-
21 ties. Such format shall include—

22 "(I) concise explanations of how
23 to interpret the data (such as a plain
24 English explanation of data reflecting

1 'nursing home staff hours per resident
2 day');
3 ''(II) differences in types of staff
4 (such as training associated with dif-
5 ferent categories of staff);
6 ''(III) the relationship between
7 nurse staffing levels and quality of
8 care; and
9 ''(IV) an explanation that appro-
10 priate staffing levels vary based on
11 patient case mix.
12 ''(ii) Links to State Internet websites
13 with information regarding State survey
14 and certification programs, links to Form
15 2567 State inspection reports (or a suc-
16 cessor form) on such websites, information
17 to guide consumers in how to interpret and
18 understand such reports, and the facility
19 plan of correction or other response to
20 such report. Any such links shall be posted
21 on a timely basis.
22 ''(iii) The standardized complaint
23 form developed under section 1128I(f), in-
24 cluding explanatory material on what com-
25 plaint forms are, how they are used, and

how to file a complaint with the State survey and certification program and the State long-term care ombudsman program.

"(iv) Summary information on the number, type, severity, and outcome of substantiated complaints.

"(v) The number of adjudicated instances of criminal violations by a facility or the employees of a facility—

"(I) that were committed inside the facility;

"(II) with respect to such instances of violations or crimes committed inside of the facility that were the violations or crimes of abuse, neglect, and exploitation, criminal sexual abuse, or other violations or crimes that resulted in serious bodily injury; and

"(III) the number of civil monetary penalties levied against the facility, employees, contractors, and other agents.

"(B) DEADLINE FOR PROVISION OF INFORMATION.—

"(i) IN GENERAL.—Except as provided in clause (ii), the Secretary shall ensure that the information described in subparagraph (A) is included on such website (or a successor website) not later than 1 year after the date of the enactment of this subsection.

"(ii) EXCEPTION.—The Secretary shall ensure that the information described in subparagraph (A)(i) is included on such website (or a successor website) not later than the date on which the requirements under section 1128I(g) are implemented.

"(2) REVIEW AND MODIFICATION OF WEBSITE.—

"(A) IN GENERAL.—The Secretary shall establish a process—

"(i) to review the accuracy, clarity of presentation, timeliness, and comprehensiveness of information reported on such website as of the day before the date of the enactment of this subsection; and

"(ii) not later than 1 year after the date of the enactment of this subsection, to modify or revamp such website in accord-

ance with the review conducted under clause (i).

"(B) CONSULTATION.—In conducting the review under subparagraph (A)(i), the Secretary shall consult with—

"(i) State long-term care ombudsman programs;

"(ii) consumer advocacy groups;

"(iii) provider stakeholder groups; and

"(iv) any other representatives of programs or groups the Secretary determines appropriate.".

(2) TIMELINESS OF SUBMISSION OF SURVEY AND CERTIFICATION INFORMATION.—

(A) IN GENERAL.—Section 1819(g)(5) of the Social Security Act (42 U.S.C. 1395i–3(g)(5)) is amended by adding at the end the following new subparagraph:

"(E) SUBMISSION OF SURVEY AND CERTIFICATION INFORMATION TO THE SECRETARY.—In order to improve the timeliness of information made available to the public under subparagraph (A) and provided on the Nursing Home Compare Medicare website under subsection (i), each State shall submit information

respecting any survey or certification made respecting a skilled nursing facility (including any enforcement actions taken by the State) to the Secretary not later than the date on which the State sends such information to the facility. The Secretary shall use the information submitted under the preceding sentence to update the information provided on the Nursing Home Compare Medicare website as expeditiously as practicable but not less frequently than quarterly.''.

(B) EFFECTIVE DATE.—The amendment made by this paragraph shall take effect 1 year after the date of the enactment of this Act.

(3) SPECIAL FOCUS FACILITY PROGRAM.—Section 1819(f) of the Social Security Act (42 U.S.C. 1395i–3(f)) is amended by adding at the end the following new paragraph:

''(8) SPECIAL FOCUS FACILITY PROGRAM.—

''(A) IN GENERAL.—The Secretary shall conduct a special focus facility program for enforcement of requirements for skilled nursing facilities that the Secretary has identified as having substantially failed to meet applicable requirement of this Act.

1 "(B) PERIODIC SURVEYS.—Under such
2 program the Secretary shall conduct surveys of
3 each facility in the program not less than once
4 every 6 months.".
5 (b) NURSING FACILITIES.—
6 (1) IN GENERAL.—Section 1919 of the Social
7 Security Act (42 U.S.C. 1396r) is amended—
8 (A) by redesignating subsection (i) as sub-
9 section (j); and
10 (B) by inserting after subsection (h) the
11 following new subsection:
12 "(i) NURSING HOME COMPARE WEBSITE.—
13 "(1) INCLUSION OF ADDITIONAL INFORMA-
14 TION.—
15 "(A) IN GENERAL.—The Secretary shall
16 ensure that the Department of Health and
17 Human Services includes, as part of the infor-
18 mation provided for comparison of nursing
19 homes on the official Internet website of the
20 Federal Government for Medicare beneficiaries
21 (commonly referred to as the 'Nursing Home
22 Compare' Medicare website) (or a successor
23 website), the following information in a manner
24 that is prominent, updated on a timely basis,
25 easily accessible, readily understandable to con-

1 sumers of long-term care services, and search-
2 able:
3 "(i) Staffing data for each facility (in-
4 cluding resident census data and data on
5 the hours of care provided per resident per
6 day) based on data submitted under sec-
7 tion 1128I(g), including information on
8 staffing turnover and tenure, in a format
9 that is clearly understandable to con-
10 sumers of long-term care services and al-
11 lows such consumers to compare dif-
12 ferences in staffing between facilities and
13 State and national averages for the facili-
14 ties. Such format shall include—
15 "(I) concise explanations of how
16 to interpret the data (such as plain
17 English explanation of data reflecting
18 'nursing home staff hours per resident
19 day');
20 "(II) differences in types of staff
21 (such as training associated with dif-
22 ferent categories of staff);
23 "(III) the relationship between
24 nurse staffing levels and quality of
25 care; and

"(IV) an explanation that appropriate staffing levels vary based on patient case mix.

"(ii) Links to State Internet websites with information regarding State survey and certification programs, links to Form 2567 State inspection reports (or a successor form) on such websites, information to guide consumers in how to interpret and understand such reports, and the facility plan of correction or other response to such report. Any such links shall be posted on a timely basis.

"(iii) The standardized complaint form developed under section 1128I(f), including explanatory material on what complaint forms are, how they are used, and how to file a complaint with the State survey and certification program and the State long-term care ombudsman program.

"(iv) Summary information on the number, type, severity, and outcome of substantiated complaints.

"(v) The number of adjudicated instances of criminal violations by a facility or the employees of a facility—

"(I) that were committed inside of the facility; and

"(II) with respect to such instances of violations or crimes committed outside of the facility, that were violations or crimes that resulted in the serious bodily injury of an elder.

"(B) DEADLINE FOR PROVISION OF INFORMATION.—

"(i) IN GENERAL.—Except as provided in clause (ii), the Secretary shall ensure that the information described in subparagraph (A) is included on such website (or a successor website) not later than 1 year after the date of the enactment of this subsection.

"(ii) EXCEPTION.—The Secretary shall ensure that the information described in subparagraph (A)(i) is included on such website (or a successor website) not later

than the date on which the requirements under section 1128I(g) are implemented.

"(2) REVIEW AND MODIFICATION OF WEBSITE.—

"(A) IN GENERAL.—The Secretary shall establish a process—

"(i) to review the accuracy, clarity of presentation, timeliness, and comprehensiveness of information reported on such website as of the day before the date of the enactment of this subsection; and

"(ii) not later than 1 year after the date of the enactment of this subsection, to modify or revamp such website in accordance with the review conducted under clause (i).

"(B) CONSULTATION.—In conducting the review under subparagraph (A)(i), the Secretary shall consult with—

"(i) State long-term care ombudsman programs;

"(ii) consumer advocacy groups;

"(iii) provider stakeholder groups;

"(iv) skilled nursing facility employees and their representatives; and

"(v) any other representatives of programs or groups the Secretary determines appropriate.".

(2) TIMELINESS OF SUBMISSION OF SURVEY AND CERTIFICATION INFORMATION.—

(A) IN GENERAL.—Section 1919(g)(5) of the Social Security Act (42 U.S.C. 1396r(g)(5)) is amended by adding at the end the following new subparagraph:

"(E) SUBMISSION OF SURVEY AND CERTIFICATION INFORMATION TO THE SECRETARY.—In order to improve the timeliness of information made available to the public under subparagraph (A) and provided on the Nursing Home Compare Medicare website under subsection (i), each State shall submit information respecting any survey or certification made respecting a nursing facility (including any enforcement actions taken by the State) to the Secretary not later than the date on which the State sends such information to the facility. The Secretary shall use the information submitted under the preceding sentence to update the information provided on the Nursing Home Compare Medicare website as expeditiously as

practicable but not less frequently than quarterly.''.

(B) EFFECTIVE DATE.—The amendment made by this paragraph shall take effect 1 year after the date of the enactment of this Act.

(3) SPECIAL FOCUS FACILITY PROGRAM.—Section 1919(f) of the Social Security Act (42 U.S.C. 1396r(f)) is amended by adding at the end of the following new paragraph:

''(10) SPECIAL FOCUS FACILITY PROGRAM.—

''(A) IN GENERAL.—The Secretary shall conduct a special focus facility program for enforcement of requirements for nursing facilities that the Secretary has identified as having substantially failed to meet applicable requirements of this Act.

''(B) PERIODIC SURVEYS.—Under such program the Secretary shall conduct surveys of each facility in the program not less often than once every 6 months.''.

(c) AVAILABILITY OF REPORTS ON SURVEYS, CERTIFICATIONS, AND COMPLAINT INVESTIGATIONS.—

(1) SKILLED NURSING FACILITIES.—Section 1819(d)(1) of the Social Security Act (42 U.S.C. 1395i–3(d)(1)), as amended by section 6101, is

amended by adding at the end the following new subparagraph:

"(C) AVAILABILITY OF SURVEY, CERTIFICATION, AND COMPLAINT INVESTIGATION REPORTS.—A skilled nursing facility must—

"(i) have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years available for any individual to review upon request; and

"(ii) post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.

The facility shall not make available under clause (i) identifying information about complainants or residents.".

(2) NURSING FACILITIES.—Section 1919(d)(1) of the Social Security Act (42 U.S.C. 1396r(d)(1)), as amended by section 6101, is amended by adding at the end the following new subparagraph:

"(V) AVAILABILITY OF SURVEY, CERTIFICATION, AND COMPLAINT INVESTIGATION REPORTS.—A nursing facility must—

"(i) have reports with respect to any surveys, certifications, and complaint in-

vestigations made respecting the facility during the 3 preceding years available for any individual to review upon request; and

"(ii) post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. The facility shall not make available under clause (i) identifying information about complainants or residents.".

(3) EFFECTIVE DATE.—The amendments made by this subsection shall take effect 1 year after the date of the enactment of this Act.

(d) GUIDANCE TO STATES ON FORM 2567 STATE INSPECTION REPORTS AND COMPLAINT INVESTIGATION REPORTS.—

(1) GUIDANCE.—The Secretary of Health and Human Services (in this subtitle referred to as the "Secretary") shall provide guidance to States on how States can establish electronic links to Form 2567 State inspection reports (or a successor form), complaint investigation reports, and a facility's plan of correction or other response to such Form 2567 State inspection reports (or a successor form) on the Internet website of the State that provides information on skilled nursing facilities and nursing facili-

ties and the Secretary shall, if possible, include such information on Nursing Home Compare.

(2) REQUIREMENT.—Section 1902(a)(9) of the Social Security Act (42 U.S.C. 1396a(a)(9)) is amended—

(A) by striking ''and'' at the end of subparagraph (B);

(B) by striking the semicolon at the end of subparagraph (C) and inserting '', and''; and

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

''(D) that the State maintain a consumer-oriented website providing useful information to consumers regarding all skilled nursing facilities and all nursing facilities in the State, including for each facility, Form 2567 State inspection reports (or a successor form), complaint investigation reports, the facility's plan of correction, and such other information that the State or the Secretary considers useful in assisting the public to assess the quality of long term care options and the quality of care provided by individual facilities;''.

(3) DEFINITIONS.—In this subsection:

(A) NURSING FACILITY.—The term ''nursing facility'' has the meaning given such term in section 1919(a) of the Social Security Act (42 U.S.C. 1396r(a)).

(B) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(C) SKILLED NURSING FACILITY.—The term ''skilled nursing facility'' has the meaning given such term in section 1819(a) of the Social Security Act (42 U.S.C. 1395i–3(a)).

(e) DEVELOPMENT OF CONSUMER RIGHTS INFORMATION PAGE ON NURSING HOME COMPARE WEBSITE.—Not later than 1 year after the date of enactment of this Act, the Secretary shall ensure that the Department of Health and Human Services, as part of the information provided for comparison of nursing facilities on the Nursing Home Compare Medicare website develops and includes a consumer rights information page that contains links to descriptions of, and information with respect to, the following:

(1) The documentation on nursing facilities that is available to the public.

(2) General information and tips on choosing a nursing facility that meets the needs of the individual.

(3) General information on consumer rights with respect to nursing facilities.

(4) The nursing facility survey process (on a national and State-specific basis).

(5) On a State-specific basis, the services available through the State long-term care ombudsman for such State.

SEC. 6104. REPORTING OF EXPENDITURES.

Section 1888 of the Social Security Act (42 U.S.C. 1395yy) is amended by adding at the end the following new subsection:

''(f) REPORTING OF DIRECT CARE EXPENDITURES.—

''(1) IN GENERAL.—For cost reports submitted under this title for cost reporting periods beginning on or after the date that is 2 years after the date of the enactment of this subsection, skilled nursing facilities shall separately report expenditures for wages and benefits for direct care staff (breaking out (at a minimum) registered nurses, licensed professional nurses, certified nurse assistants, and other medical and therapy staff).

1 "(2) MODIFICATION OF FORM.—The Secretary,
2 in consultation with private sector accountants expe-
3 rienced with Medicare and Medicaid nursing facility
4 home cost reports, shall redesign such reports to
5 meet the requirement of paragraph (1) not later
6 than 1 year after the date of the enactment of this
7 subsection.

8 "(3) CATEGORIZATION BY FUNCTIONAL AC-
9 COUNTS.—Not later than 30 months after the date
10 of the enactment of this subsection, the Secretary,
11 working in consultation with the Medicare Payment
12 Advisory Commission, the Medicaid and CHIP Pay-
13 ment and Access Commission, the Inspector General
14 of the Department of Health and Human Services,
15 and other expert parties the Secretary determines
16 appropriate, shall take the expenditures listed on
17 cost reports, as modified under paragraph (1), sub-
18 mitted by skilled nursing facilities and categorize
19 such expenditures, regardless of any source of pay-
20 ment for such expenditures, for each skilled nursing
21 facility into the following functional accounts on an
22 annual basis:

23 "(A) Spending on direct care services (in-
24 cluding nursing, therapy, and medical services).

"(B) Spending on indirect care (including housekeeping and dietary services).

"(C) Capital assets (including building and land costs).

"(D) Administrative services costs.

"(4) AVAILABILITY OF INFORMATION SUBMITTED.—The Secretary shall establish procedures to make information on expenditures submitted under this subsection readily available to interested parties upon request, subject to such requirements as the Secretary may specify under the procedures established under this paragraph.".

SEC. 6105. STANDARDIZED COMPLAINT FORM.

(a) IN GENERAL.—Section 1128I of the Social Security Act, as added and amended by this Act, is amended by adding at the end the following new subsection:

"(f) STANDARDIZED COMPLAINT FORM.—

"(1) DEVELOPMENT BY THE SECRETARY.—The Secretary shall develop a standardized complaint form for use by a resident (or a person acting on the resident's behalf) in filing a complaint with a State survey and certification agency and a State long-term care ombudsman program with respect to a facility.

"(2) COMPLAINT FORMS AND RESOLUTION PROCESSES.—

"(A) COMPLAINT FORMS.—The State must make the standardized complaint form developed under paragraph (1) available upon request to—

"(i) a resident of a facility; and

"(ii) any person acting on the resident's behalf.

"(B) COMPLAINT RESOLUTION PROCESS.—The State must establish a complaint resolution process in order to ensure that the legal representative of a resident of a facility or other responsible party is not denied access to such resident or otherwise retaliated against if they have complained about the quality of care provided by the facility or other issues relating to the facility. Such complaint resolution process shall include—

"(i) procedures to assure accurate tracking of complaints received, including notification to the complainant that a complaint has been received;

"(ii) procedures to determine the likely severity of a complaint and for the investigation of the complaint; and

"(iii) deadlines for responding to a complaint and for notifying the complainant of the outcome of the investigation.

"(3) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed as preventing a resident of a facility (or a person acting on the resident's behalf) from submitting a complaint in a manner or format other than by using the standardized complaint form developed under paragraph (1) (including submitting a complaint orally).".

(b) EFFECTIVE DATE.—The amendment made by this section shall take effect 1 year after the date of the enactment of this Act.

SEC. 6106. ENSURING STAFFING ACCOUNTABILITY.

Section 1128I of the Social Security Act, as added and amended by this Act, is amended by adding at the end the following new subsection:

"(g) SUBMISSION OF STAFFING INFORMATION BASED ON PAYROLL DATA IN A UNIFORM FORMAT.—Beginning not later than 2 years after the date of the enactment of this subsection, and after consulting with State long-term care ombudsman programs, consumer advocacy

1 groups, provider stakeholder groups, employees and their
2 representatives, and other parties the Secretary deems ap-
3 propriate, the Secretary shall require a facility to elec-
4 tronically submit to the Secretary direct care staffing in-
5 formation (including information with respect to agency
6 and contract staff) based on payroll and other verifiable
7 and auditable data in a uniform format (according to spec-
8 ifications established by the Secretary in consultation with
9 such programs, groups, and parties). Such specifications
10 shall require that the information submitted under the
11 preceding sentence—

12 ''(1) specify the category of work a certified em-
13 ployee performs (such as whether the employee is a
14 registered nurse, licensed practical nurse, licensed
15 vocational nurse, certified nursing assistant, thera-
16 pist, or other medical personnel);

17 ''(2) include resident census data and informa-
18 tion on resident case mix;

19 ''(3) include a regular reporting schedule; and

20 ''(4) include information on employee turnover
21 and tenure and on the hours of care provided by
22 each category of certified employees referenced in
23 paragraph (1) per resident per day.

24 Nothing in this subsection shall be construed as pre-
25 venting the Secretary from requiring submission of such

information with respect to specific categories, such as nursing staff, before other categories of certified employees. Information under this subsection with respect to agency and contract staff shall be kept separate from information on employee staffing.''.

SEC. 6107. GAO STUDY AND REPORT ON FIVE-STAR QUALITY RATING SYSTEM.

(a) STUDY.—The Comptroller General of the United States (in this section referred to as the ''Comptroller General'') shall conduct a study on the Five-Star Quality Rating System for nursing homes of the Centers for Medicare & Medicaid Services. Such study shall include an analysis of—

(1) how such system is being implemented;

(2) any problems associated with such system or its implementation; and

(3) how such system could be improved.

(b) REPORT.—Not later than 2 years after the date of enactment of this Act, the Comptroller General shall submit to Congress a report containing the results of the study conducted under subsection (a), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

PART II—TARGETING ENFORCEMENT

SEC. 6111. CIVIL MONEY PENALTIES.

(a) SKILLED NURSING FACILITIES.—

(1) IN GENERAL.—Section 1819(h)(2)(B)(ii) of the Social Security Act (42 U.S.C. 1395i–3(h)(2)(B)(ii)) is amended—

(A) by striking ''PENALTIES.—The Secretary'' and inserting ''PENALTIES.—

''(I) IN GENERAL.—Subject to subclause (II), the Secretary''; and

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

''(II) REDUCTION OF CIVIL MONEY PENALTIES IN CERTAIN CIRCUMSTANCES.—Subject to subclause (III), in the case where a facility self-reports and promptly corrects a deficiency for which a penalty was imposed under this clause not later than 10 calendar days after the date of such imposition, the Secretary may reduce the amount of the penalty imposed by not more than 50 percent.

''(III) PROHIBITIONS ON REDUCTION FOR CERTAIN DEFICIENCIES.—

"(aa) REPEAT DEFICIENCIES.—The Secretary may not reduce the amount of a penalty under subclause (II) if the Secretary had reduced a penalty imposed on the facility in the preceding year under such subclause with respect to a repeat deficiency.

"(bb) CERTAIN OTHER DEFICIENCIES.—The Secretary may not reduce the amount of a penalty under subclause (II) if the penalty is imposed on the facility for a deficiency that is found to result in a pattern of harm or widespread harm, immediately jeopardizes the health or safety of a resident or residents of the facility, or results in the death of a resident of the facility.

"(IV) COLLECTION OF CIVIL MONEY PENALTIES.—In the case of a civil money penalty imposed under

this clause, the Secretary shall issue regulations that—

"(aa) subject to item (cc), not later than 30 days after the imposition of the penalty, provide for the facility to have the opportunity to participate in an independent informal dispute resolution process which generates a written record prior to the collection of such penalty;

"(bb) in the case where the penalty is imposed for each day of noncompliance, provide that a penalty may not be imposed for any day during the period beginning on the initial day of the imposition of the penalty and ending on the day on which the informal dispute resolution process under item (aa) is completed;

"(cc) may provide for the collection of such civil money penalty and the placement of such amounts collected in an es-

crow account under the direction of the Secretary on the earlier of the date on which the informal dispute resolution process under item (aa) is completed or the date that is 90 days after the date of the imposition of the penalty;

"(dd) may provide that such amounts collected are kept in such account pending the resolution of any subsequent appeals;

"(ee) in the case where the facility successfully appeals the penalty, may provide for the return of such amounts collected (plus interest) to the facility; and

"(ff) in the case where all such appeals are unsuccessful, may provide that some portion of such amounts collected may be used to support activities that benefit residents, including assistance to support and protect residents of a facility that closes

(voluntarily or involuntarily) or is decertified (including offsetting costs of relocating residents to home and community-based settings or another facility), projects that support resident and family councils and other consumer involvement in assuring quality care in facilities, and facility improvement initiatives approved by the Secretary (including joint training of facility staff and surveyors, technical assistance for facilities implementing quality assurance programs, the appointment of temporary management firms, and other activities approved by the Secretary).''.

(2) CONFORMING AMENDMENT.—The second sentence of section 1819(h)(5) of the Social Security Act (42 U.S.C. 1395i–3(h)(5)) is amended by inserting ''(ii)(IV),'' after ''(i),''.

(b) NURSING FACILITIES.—

(1) IN GENERAL.—Section 1919(h)(3)(C)(ii) of the Social Security Act (42 U.S.C. 1396r(h)(3)(C)) is amended—

(A) by striking ''PENALTIES.—The Secretary'' and inserting ''PENALTIES.—

''(I) IN GENERAL.—Subject to subclause (II), the Secretary''; and

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

''(II) REDUCTION OF CIVIL MONEY PENALTIES IN CERTAIN CIRCUMSTANCES.—Subject to subclause (III), in the case where a facility self-reports and promptly corrects a deficiency for which a penalty was imposed under this clause not later than 10 calendar days after the date of such imposition, the Secretary may reduce the amount of the penalty imposed by not more than 50 percent.

''(III) PROHIBITIONS ON REDUCTION FOR CERTAIN DEFICIENCIES.—

''(aa) REPEAT DEFICIENCIES.—The Secretary may not reduce the amount of a pen-

alty under subclause (II) if the Secretary had reduced a penalty imposed on the facility in the preceding year under such subclause with respect to a repeat deficiency.

"(bb) CERTAIN OTHER DEFICIENCIES.—The Secretary may not reduce the amount of a penalty under subclause (II) if the penalty is imposed on the facility for a deficiency that is found to result in a pattern of harm or widespread harm, immediately jeopardizes the health or safety of a resident or residents of the facility, or results in the death of a resident of the facility.

"(IV) COLLECTION OF CIVIL MONEY PENALTIES.—In the case of a civil money penalty imposed under this clause, the Secretary shall issue regulations that—

"(aa) subject to item (cc), not later than 30 days after the

imposition of the penalty, provide for the facility to have the opportunity to participate in an independent informal dispute resolution process which generates a written record prior to the collection of such penalty;

''(bb) in the case where the penalty is imposed for each day of noncompliance, provide that a penalty may not be imposed for any day during the period beginning on the initial day of the imposition of the penalty and ending on the day on which the informal dispute resolution process under item (aa) is completed;

''(cc) may provide for the collection of such civil money penalty and the placement of such amounts collected in an escrow account under the direction of the Secretary on the earlier of the date on which the informal dispute resolution process under

item (aa) is completed or the date that is 90 days after the date of the imposition of the penalty;

"(dd) may provide that such amounts collected are kept in such account pending the resolution of any subsequent appeals;

"(ee) in the case where the facility successfully appeals the penalty, may provide for the return of such amounts collected (plus interest) to the facility; and

"(ff) in the case where all such appeals are unsuccessful, may provide that some portion of such amounts collected may be used to support activities that benefit residents, including assistance to support and protect residents of a facility that closes (voluntarily or involuntarily) or is decertified (including offsetting costs of relocating residents to home and community-based set-

tings or another facility), projects that support resident and family councils and other consumer involvement in assuring quality care in facilities, and facility improvement initiatives approved by the Secretary (including joint training of facility staff and surveyors, technical assistance for facilities implementing quality assurance programs, the appointment of temporary management firms, and other activities approved by the Secretary).''.

(2) CONFORMING AMENDMENT.—Section 1919(h)(5)(8) of the Social Security Act (42 U.S.C. 1396r(h)(5)(8)) is amended by inserting ''(ii)(IV),'' after ''(i),''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act.

SEC. 6112. NATIONAL INDEPENDENT MONITOR DEMONSTRATION PROJECT.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall conduct a demonstration project to develop, test, and implement an independent monitor program to oversee interstate and large intrastate chains of skilled nursing facilities and nursing facilities.

(2) SELECTION.—The Secretary shall select chains of skilled nursing facilities and nursing facilities described in paragraph (1) to participate in the demonstration project under this section from among those chains that submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(3) DURATION.—The Secretary shall conduct the demonstration project under this section for a 2-year period.

(4) IMPLEMENTATION.—The Secretary shall implement the demonstration project under this section not later than 1 year after the date of the enactment of this Act.

(b) REQUIREMENTS.—The Secretary shall evaluate chains selected to participate in the demonstration project under this section based on criteria selected by the Sec-

1 retary, including where evidence suggests that a number
2 of the facilities of the chain are experiencing serious safety
3 and quality of care problems. Such criteria may include
4 the evaluation of a chain that includes a number of facili-
5 ties participating in the ''Special Focus Facility'' program
6 (or a successor program) or multiple facilities with a
7 record of repeated serious safety and quality of care defi-
8 ciencies.

9 (c) RESPONSIBILITIES.—An independent monitor
10 that enters into a contract with the Secretary to partici-
11 pate in the conduct of the demonstration project under
12 this section shall—

13 (1) conduct periodic reviews and prepare root-
14 cause quality and deficiency analyses of a chain to
15 assess if facilities of the chain are in compliance
16 with State and Federal laws and regulations applica-
17 ble to the facilities;

18 (2) conduct sustained oversight of the efforts of
19 the chain, whether publicly or privately held, to
20 achieve compliance by facilities of the chain with
21 State and Federal laws and regulations applicable to
22 the facilities;

23 (3) analyze the management structure, distribu-
24 tion of expenditures, and nurse staffing levels of fa-

cilities of the chain in relation to resident census, staff turnover rates, and tenure;

(4) report findings and recommendations with respect to such reviews, analyses, and oversight to the chain and facilities of the chain, to the Secretary, and to relevant States; and

(5) publish the results of such reviews, analyses, and oversight.

(d) IMPLEMENTATION OF RECOMMENDATIONS.—

(1) RECEIPT OF FINDING BY CHAIN.—Not later than 10 days after receipt of a finding of an independent monitor under subsection (c)(4), a chain participating in the demonstration project shall submit to the independent monitor a report—

(A) outlining corrective actions the chain will take to implement the recommendations in such report; or

(B) indicating that the chain will not implement such recommendations, and why it will not do so.

(2) RECEIPT OF REPORT BY INDEPENDENT MONITOR.—Not later than 10 days after receipt of a report submitted by a chain under paragraph (1), an independent monitor shall finalize its recommendations and submit a report to the chain and

1 facilities of the chain, the Secretary, and the State
2 or States, as appropriate, containing such final rec-
3 ommendations.

4 (e) COST OF APPOINTMENT.—A chain shall be re-
5 sponsible for a portion of the costs associated with the
6 appointment of independent monitors under the dem-
7 onstration project under this section. The chain shall pay
8 such portion to the Secretary (in an amount and in ac-
9 cordance with procedures established by the Secretary).

10 (f) WAIVER AUTHORITY.—The Secretary may waive
11 such requirements of titles XVIII and XIX of the Social
12 Security Act (42 U.S.C. 1395 et seq.; 1396 et seq.) as
13 may be necessary for the purpose of carrying out the dem-
14 onstration project under this section.

15 (g) AUTHORIZATION OF APPROPRIATIONS.—There
16 are authorized to be appropriated such sums as may be
17 necessary to carry out this section.

18 (h) DEFINITIONS.—In this section:

19 (1) ADDITIONAL DISCLOSABLE PARTY.—The
20 term ''additional disclosable party'' has the meaning
21 given such term in section 1124(c)(5)(A) of the So-
22 cial Security Act, as added by section 4201(a).

23 (2) FACILITY.—The term ''facility'' means a
24 skilled nursing facility or a nursing facility.

1 (3) NURSING FACILITY.—The term ''nursing
2 facility'' has the meaning given such term in section
3 1919(a) of the Social Security Act (42 U.S.C.
4 1396r(a)).
5 (4) SECRETARY.—The term ''Secretary'' means
6 the Secretary of Health and Human Services, acting
7 through the Assistant Secretary for Planning and
8 Evaluation.
9 (5) SKILLED NURSING FACILITY.—The term
10 ''skilled nursing facility'' has the meaning given such
11 term in section 1819(a) of the Social Security Act
12 (42 U.S.C. 1395(a)).
13 (i) EVALUATION AND REPORT.—
14 (1) EVALUATION.—The Secretary, in consulta-
15 tion with the Inspector General of the Department
16 of Health and Human Services, shall evaluate the
17 demonstration project conducted under this section.
18 (2) REPORT.—Not later than 180 days after
19 the completion of the demonstration project under
20 this section, the Secretary shall submit to Congress
21 a report containing the results of the evaluation con-
22 ducted under paragraph (1), together with rec-
23 ommendations—

(A) as to whether the independent monitor program should be established on a permanent basis;

(B) if the Secretary recommends that such program be so established, on appropriate procedures and mechanisms for such establishment; and

(C) for such legislation and administrative action as the Secretary determines appropriate.

SEC. 6113. NOTIFICATION OF FACILITY CLOSURE.

(a) IN GENERAL.—Section 1128I of the Social Security Act, as added and amended by this Act, is amended by adding at the end the following new subsection:

''(h) NOTIFICATION OF FACILITY CLOSURE.—

''(1) IN GENERAL.—Any individual who is the administrator of a facility must—

''(A) submit to the Secretary, the State long-term care ombudsman, residents of the facility, and the legal representatives of such residents or other responsible parties, written notification of an impending closure—

''(i) subject to clause (ii), not later than the date that is 60 days prior to the date of such closure; and

"(ii) in the case of a facility where the Secretary terminates the facility's participation under this title, not later than the date that the Secretary determines appropriate;

"(B) ensure that the facility does not admit any new residents on or after the date on which such written notification is submitted; and

"(C) include in the notice a plan for the transfer and adequate relocation of the residents of the facility by a specified date prior to closure that has been approved by the State, including assurances that the residents will be transferred to the most appropriate facility or other setting in terms of quality, services, and location, taking into consideration the needs, choice, and best interests of each resident.

"(2) RELOCATION.—

"(A) IN GENERAL.—The State shall ensure that, before a facility closes, all residents of the facility have been successfully relocated to another facility or an alternative home and community-based setting.

"(B) CONTINUATION OF PAYMENTS UNTIL RESIDENTS RELOCATED.—The Secretary may, as the Secretary determines appropriate, continue to make payments under this title with respect to residents of a facility that has submitted a notification under paragraph (1) during the period beginning on the date such notification is submitted and ending on the date on which the resident is successfully relocated.

"(3) SANCTIONS.—Any individual who is the administrator of a facility that fails to comply with the requirements of paragraph (1)—

"(A) shall be subject to a civil monetary penalty of up to $100,000;

"(B) may be subject to exclusion from participation in any Federal health care program (as defined in section 1128B(f)); and

"(C) shall be subject to any other penalties that may be prescribed by law.

"(4) PROCEDURE.—The provisions of section 1128A (other than subsections (a) and (b) and the second sentence of subsection (f)) shall apply to a civil money penalty or exclusion under paragraph (3) in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).".

(b) CONFORMING AMENDMENTS.—Section 1819(h)(4) of the Social Security Act (42 U.S.C. 1395i–3(h)(4)) is amended—

(1) in the first sentence, by striking ''the Secretary shall terminate'' and inserting ''the Secretary, subject to section 1128I(h), shall terminate''; and

(2) in the second sentence, by striking ''subsection (c)(2)'' and inserting ''subsection (c)(2) and section 1128I(h)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act.

SEC. 6114. NATIONAL DEMONSTRATION PROJECTS ON CULTURE CHANGE AND USE OF INFORMATION TECHNOLOGY IN NURSING HOMES.

(a) IN GENERAL.—The Secretary shall conduct 2 demonstration projects, 1 for the development of best practices in skilled nursing facilities and nursing facilities that are involved in the culture change movement (including the development of resources for facilities to find and access funding in order to undertake culture change) and 1 for the development of best practices in skilled nursing facilities and nursing facilities for the use of information technology to improve resident care.

(b) CONDUCT OF DEMONSTRATION PROJECTS.—

(1) GRANT AWARD.—Under each demonstration project conducted under this section, the Secretary shall award 1 or more grants to facility-based settings for the development of best practices described in subsection (a) with respect to the demonstration project involved. Such award shall be made on a competitive basis and may be allocated in 1 lump-sum payment.

(2) CONSIDERATION OF SPECIAL NEEDS OF RESIDENTS.—Each demonstration project conducted under this section shall take into consideration the special needs of residents of skilled nursing facilities and nursing facilities who have cognitive impairment, including dementia.

(c) DURATION AND IMPLEMENTATION.—

(1) DURATION.—The demonstration projects shall each be conducted for a period not to exceed 3 years.

(2) IMPLEMENTATION.—The demonstration projects shall each be implemented not later than 1 year after the date of the enactment of this Act.

(d) DEFINITIONS.—In this section:

(1) NURSING FACILITY.—The term ''nursing facility'' has the meaning given such term in section

1919(a) of the Social Security Act (42 U.S.C. 1396r(a)).

(2) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(3) SKILLED NURSING FACILITY.—The term ''skilled nursing facility'' has the meaning given such term in section 1819(a) of the Social Security Act (42 U.S.C. 1395(a)).

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

(f) REPORT.—Not later than 9 months after the completion of the demonstration project, the Secretary shall submit to Congress a report on such project, together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

PART III—IMPROVING STAFF TRAINING

SEC. 6121. DEMENTIA AND ABUSE PREVENTION TRAINING.

(a) SKILLED NURSING FACILITIES.—

(1) IN GENERAL.—Section 1819(f)(2)(A)(i)(I) of the Social Security Act (42 U.S.C. 1395i–3(f)(2)(A)(i)(I)) is amended by inserting ''(including, in the case of initial training and, if the Secretary determines appropriate, in the case of ongo-

ing training, dementia management training, and patient abuse prevention training'' before '', (II)''.

(2) CLARIFICATION OF DEFINITION OF NURSE AIDE.—Section 1819(b)(5)(F) of the Social Security Act (42 U.S.C. 1395i–3(b)(5)(F)) is amended by adding at the end the following flush sentence:

''Such term includes an individual who provides such services through an agency or under a contract with the facility.''.

(b) NURSING FACILITIES.—

(1) IN GENERAL.—Section 1919(f)(2)(A)(i)(I) of the Social Security Act (42 U.S.C. 1396r(f)(2)(A)(i)(I)) is amended by inserting ''(including, in the case of initial training and, if the Secretary determines appropriate, in the case of ongoing training, dementia management training, and patient abuse prevention training'' before '', (II)''.

(2) CLARIFICATION OF DEFINITION OF NURSE AIDE.—Section 1919(b)(5)(F) of the Social Security Act (42 U.S.C. 1396r(b)(5)(F)) is amended by adding at the end the following flush sentence:

''Such term includes an individual who provides such services through an agency or under a contract with the facility.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act.

Subtitle C—Nationwide Program for National and State Background Checks on Direct Patient Access Employees of Long-term Care Facilities and Providers

SEC. 6201. NATIONWIDE PROGRAM FOR NATIONAL AND STATE BACKGROUND CHECKS ON DIRECT PATIENT ACCESS EMPLOYEES OF LONG-TERM CARE FACILITIES AND PROVIDERS.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary''), shall establish a program to identify efficient, effective, and economical procedures for long term care facilities or providers to conduct background checks on prospective direct patient access employees on a nationwide basis (in this subsection, such program shall be referred to as the ''nationwide program''). Except for the following modifications, the Secretary shall carry out the nationwide program under similar terms and conditions as the pilot program under section 307 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub-

lic Law 108–173; 117 Stat. 2257), including the prohibition on hiring abusive workers and the authorization of the imposition of penalties by a participating State under subsection (b)(3)(A) and (b)(6), respectively, of such section 307:

(1) AGREEMENTS.—

(A) NEWLY PARTICIPATING STATES.—The Secretary shall enter into agreements with each State—

(i) that the Secretary has not entered into an agreement with under subsection (c)(1) of such section 307;

(ii) that agrees to conduct background checks under the nationwide program on a Statewide basis; and

(iii) that submits an application to the Secretary containing such information and at such time as the Secretary may specify.

(B) CERTAIN PREVIOUSLY PARTICIPATING STATES.—The Secretary shall enter into agreements with each State—

(i) that the Secretary has entered into an agreement with under such subsection (c)(1), but only in the case where such agreement did not require the State to

conduct background checks under the program established under subsection (a) of such section 307 on a Statewide basis;

(ii) that agrees to conduct background checks under the nationwide program on a Statewide basis; and

(iii) that submits an application to the Secretary containing such information and at such time as the Secretary may specify.

(2) NONAPPLICATION OF SELECTION CRITERIA.—The selection criteria required under subsection (c)(3)(B) of such section 307 shall not apply.

(3) REQUIRED FINGERPRINT CHECK AS PART OF CRIMINAL HISTORY BACKGROUND CHECK.—The procedures established under subsection (b)(1) of such section 307 shall—

(A) require that the long-term care facility or provider (or the designated agent of the long-term care facility or provider) obtain State and national criminal history background checks on the prospective employee through such means as the Secretary determines appropriate, efficient, and effective that utilize a search of State-based abuse and neglect registries and databases, including the abuse and

1 neglect registries of another State in the case
2 where a prospective employee previously resided
3 in that State, State criminal history records,
4 the records of any proceedings in the State that
5 may contain disqualifying information about
6 prospective employees (such as proceedings con-
7 ducted by State professional licensing and dis-
8 ciplinary boards and State Medicaid Fraud
9 Control Units), and Federal criminal history
10 records, including a fingerprint check using the
11 Integrated Automated Fingerprint Identifica-
12 tion System of the Federal Bureau of Investiga-
13 tion;
14 (B) require States to describe and test
15 methods that reduce duplicative fingerprinting,
16 including providing for the development of ''rap
17 back'' capability by the State such that, if a di-
18 rect patient access employee of a long-term care
19 facility or provider is convicted of a crime fol-
20 lowing the initial criminal history background
21 check conducted with respect to such employee,
22 and the employee's fingerprints match the
23 prints on file with the State law enforcement
24 department, the department will immediately
25 inform the State and the State will immediately

1 inform the long-term care facility or provider
2 which employs the direct patient access em-
3 ployee of such conviction; and
4 (C) require that criminal history back-
5 ground checks conducted under the nationwide
6 program remain valid for a period of time speci-
7 fied by the Secretary.
8 (4) STATE REQUIREMENTS.—An agreement en-
9 tered into under paragraph (1) shall require that a
10 participating State—
11 (A) be responsible for monitoring compli-
12 ance with the requirements of the nationwide
13 program;
14 (B) have procedures in place to—
15 (i) conduct screening and criminal his-
16 tory background checks under the nation-
17 wide program in accordance with the re-
18 quirements of this section;
19 (ii) monitor compliance by long-term
20 care facilities and providers with the proce-
21 dures and requirements of the nationwide
22 program;
23 (iii) as appropriate, provide for a pro-
24 visional period of employment by a long-
25 term care facility or provider of a direct

1 patient access employee, not to exceed 60
2 days, pending completion of the required
3 criminal history background check and, in
4 the case where the employee has appealed
5 the results of such background check,
6 pending completion of the appeals process,
7 during which the employee shall be subject
8 to direct on-site supervision (in accordance
9 with procedures established by the State to
10 ensure that a long-term care facility or
11 provider furnishes such direct on-site su-
12 pervision);
13 (iv) provide an independent process by
14 which a provisional employee or an em-
15 ployee may appeal or dispute the accuracy
16 of the information obtained in a back-
17 ground check performed under the nation-
18 wide program, including the specification
19 of criteria for appeals for direct patient ac-
20 cess employees found to have disqualifying
21 information which shall include consider-
22 ation of the passage of time, extenuating
23 circumstances, demonstration of rehabilita-
24 tion, and relevancy of the particular dis-

1 qualifying information with respect to the
2 current employment of the individual;
3 (v) provide for the designation of a
4 single State agency as responsible for—
5 (I) overseeing the coordination of
6 any State and national criminal his-
7 tory background checks requested by
8 a long-term care facility or provider
9 (or the designated agent of the long-
10 term care facility or provider) utilizing
11 a search of State and Federal crimi-
12 nal history records, including a finger-
13 print check of such records;
14 (II) overseeing the design of ap-
15 propriate privacy and security safe-
16 guards for use in the review of the re-
17 sults of any State or national criminal
18 history background checks conducted
19 regarding a prospective direct patient
20 access employee to determine whether
21 the employee has any conviction for a
22 relevant crime;
23 (III) immediately reporting to
24 the long-term care facility or provider
25 that requested the criminal history

1 background check the results of such
2 review; and
3 (IV) in the case of an employee
4 with a conviction for a relevant crime
5 that is subject to reporting under sec-
6 tion 1128E of the Social Security Act
7 (42 U.S.C. 1320a–7e), reporting the
8 existence of such conviction to the
9 database established under that sec-
10 tion;
11 (vi) determine which individuals are
12 direct patient access employees (as defined
13 in paragraph (6)(B)) for purposes of the
14 nationwide program;
15 (vii) as appropriate, specify offenses,
16 including convictions for violent crimes, for
17 purposes of the nationwide program; and
18 (viii) describe and test methods that
19 reduce duplicative fingerprinting, including
20 providing for the development of ''rap
21 back'' capability such that, if a direct pa-
22 tient access employee of a long-term care
23 facility or provider is convicted of a crime
24 following the initial criminal history back-
25 ground check conducted with respect to

1 such employee, and the employee's finger-
2 prints match the prints on file with the
3 State law enforcement department—
4 (I) the department will imme-
5 diately inform the State agency des-
6 ignated under clause (v) and such
7 agency will immediately inform the fa-
8 cility or provider which employs the
9 direct patient access employee of such
10 conviction; and
11 (II) the State will provide, or will
12 require the facility to provide, to the
13 employee a copy of the results of the
14 criminal history background check
15 conducted with respect to the em-
16 ployee at no charge in the case where
17 the individual requests such a copy.
18 (5) PAYMENTS.—
19 (A) NEWLY PARTICIPATING STATES.—
20 (i) IN GENERAL.—As part of the ap-
21 plication submitted by a State under para-
22 graph (1)(A)(iii), the State shall guar-
23 antee, with respect to the costs to be in-
24 curred by the State in carrying out the na-
25 tionwide program, that the State will make

available (directly or through donations from public or private entities) a particular amount of non-Federal contributions, as a condition of receiving the Federal match under clause (ii).

(ii) FEDERAL MATCH.—The payment amount to each State that the Secretary enters into an agreement with under paragraph (1)(A) shall be 3 times the amount that the State guarantees to make available under clause (i), except that in no case may the payment amount exceed $3,000,000.

(B) PREVIOUSLY PARTICIPATING STATES.—

(i) IN GENERAL.—As part of the application submitted by a State under paragraph (1)(B)(iii), the State shall guarantee, with respect to the costs to be incurred by the State in carrying out the nationwide program, that the State will make available (directly or through donations from public or private entities) a particular amount of non-Federal contributions, as a

condition of receiving the Federal match under clause (ii).

(ii) FEDERAL MATCH.—The payment amount to each State that the Secretary enters into an agreement with under paragraph (1)(B) shall be 3 times the amount that the State guarantees to make available under clause (i), except that in no case may the payment amount exceed $1,500,000.

(6) DEFINITIONS.—Under the nationwide program:

(A) CONVICTION FOR A RELEVANT CRIME.—The term ''conviction for a relevant crime'' means any Federal or State criminal conviction for—

(i) any offense described in section 1128(a) of the Social Security Act (42 U.S.C. 1320a–7); or

(ii) such other types of offenses as a participating State may specify for purposes of conducting the program in such State.

(B) DISQUALIFYING INFORMATION.—The term ''disqualifying information'' means a con-

1 viction for a relevant crime or a finding of pa-
2 tient or resident abuse.
3 (C) FINDING OF PATIENT OR RESIDENT
4 ABUSE.—The term ''finding of patient or resi-
5 dent abuse'' means any substantiated finding
6 by a State agency under section 1819(g)(1)(C)
7 or 1919(g)(1)(C) of the Social Security Act (42
8 U.S.C. 1395i–3(g)(1)(C), 1396r(g)(1)(C)) or a
9 Federal agency that a direct patient access em-
10 ployee has committed—
11 (i) an act of patient or resident abuse
12 or neglect or a misappropriation of patient
13 or resident property; or
14 (ii) such other types of acts as a par-
15 ticipating State may specify for purposes
16 of conducting the program in such State.
17 (D) DIRECT PATIENT ACCESS EM-
18 PLOYEE.—The term ''direct patient access em-
19 ployee'' means any individual who has access to
20 a patient or resident of a long-term care facility
21 or provider through employment or through a
22 contract with such facility or provider and has
23 duties that involve (or may involve) one-on-one
24 contact with a patient or resident of the facility
25 or provider, as determined by the State for pur-

poses of the nationwide program. Such term does not include a volunteer unless the volunteer has duties that are equivalent to the duties of a direct patient access employee and those duties involve (or may involve) one-on-one contact with a patient or resident of the long-term care facility or provider.

(E) LONG-TERM CARE FACILITY OR PROVIDER.—The term ''long-term care facility or provider'' means the following facilities or providers which receive payment for services under title XVIII or XIX of the Social Security Act:

(i) A skilled nursing facility (as defined in section 1819(a) of the Social Security Act (42 U.S.C. 1395i–3(a))).

(ii) A nursing facility (as defined in section 1919(a) of such Act (42 U.S.C. 1396r(a))).

(iii) A home health agency.

(iv) A provider of hospice care (as defined in section 1861(dd)(1) of such Act (42 U.S.C. 1395x(dd)(1))).

(v) A long-term care hospital (as described in section 1886(d)(1)(B)(iv) of

1 such Act (42 U.S.C.
2 1395ww(d)(1)(B)(iv))).
3 (vi) A provider of personal care serv-
4 ices.
5 (vii) A provider of adult day care.
6 (viii) A residential care provider that
7 arranges for, or directly provides, long-
8 term care services, including an assisted
9 living facility that provides a level of care
10 established by the Secretary.
11 (ix) An intermediate care facility for
12 the mentally retarded (as defined in sec-
13 tion 1905(d) of such Act (42 U.S.C.
14 1396d(d))).
15 (x) Any other facility or provider of
16 long-term care services under such titles as
17 the participating State determines appro-
18 priate.
19 (7) EVALUATION AND REPORT.—
20 (A) EVALUATION.—
21 (i) IN GENERAL.—The Inspector Gen-
22 eral of the Department of Health and
23 Human Services shall conduct an evalua-
24 tion of the nationwide program.

(ii) INCLUSION OF SPECIFIC TOPICS.—The evaluation conducted under clause (i) shall include the following:

(I) A review of the various procedures implemented by participating States for long-term care facilities or providers, including staffing agencies, to conduct background checks of direct patient access employees under the nationwide program and identification of the most appropriate, efficient, and effective procedures for conducting such background checks.

(II) An assessment of the costs of conducting such background checks (including start up and administrative costs).

(III) A determination of the extent to which conducting such background checks leads to any unintended consequences, including a reduction in the available workforce for long-term care facilities or providers.

(IV) An assessment of the impact of the nationwide program on reduc-

ing the number of incidents of neglect, abuse, and misappropriation of resident property to the extent practicable.

(V) An evaluation of other aspects of the nationwide program, as determined appropriate by the Secretary.

(B) REPORT.—Not later than 180 days after the completion of the nationwide program, the Inspector General of the Department of Health and Human Services shall submit a report to Congress containing the results of the evaluation conducted under subparagraph (A).

(b) FUNDING.—

(1) NOTIFICATION.—The Secretary of Health and Human Services shall notify the Secretary of the Treasury of the amount necessary to carry out the nationwide program under this section for the period of fiscal years 2010 through 2012, except that in no case shall such amount exceed $160,000,000.

(2) TRANSFER OF FUNDS.—

(A) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, the Sec-

retary of the Treasury shall provide for the transfer to the Secretary of Health and Human Services of the amount specified as necessary to carry out the nationwide program under paragraph (1). Such amount shall remain available until expended.

(B) RESERVATION OF FUNDS FOR CONDUCT OF EVALUATION.—The Secretary may reserve not more than $3,000,000 of the amount transferred under subparagraph (A) to provide for the conduct of the evaluation under subsection (a)(7)(A).

Subtitle D—Patient-Centered Outcomes Research

SEC. 6301. PATIENT-CENTERED OUTCOMES RESEARCH.

(a) IN GENERAL.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by adding at the end the following new part:

"PART D—COMPARATIVE CLINICAL EFFECTIVENESS RESEARCH

"COMPARATIVE CLINICAL EFFECTIVENESS RESEARCH

"SEC. 1181. (a) DEFINITIONS.—In this section:

"(1) BOARD.—The term 'Board' means the Board of Governors established under subsection (f).

1 "(2) COMPARATIVE CLINICAL EFFECTIVENESS
2 RESEARCH; RESEARCH.—
3 "(A) IN GENERAL.—The terms 'compara-
4 tive clinical effectiveness research' and 're-
5 search' mean research evaluating and com-
6 paring health outcomes and the clinical effec-
7 tiveness, risks, and benefits of 2 or more med-
8 ical treatments, services, and items described in
9 subparagraph (B).
10 "(B) MEDICAL TREATMENTS, SERVICES,
11 AND ITEMS DESCRIBED.—The medical treat-
12 ments, services, and items described in this sub-
13 paragraph are health care interventions, proto-
14 cols for treatment, care management, and deliv-
15 ery, procedures, medical devices, diagnostic
16 tools, pharmaceuticals (including drugs and
17 biologicals), integrative health practices, and
18 any other strategies or items being used in the
19 treatment, management, and diagnosis of, or
20 prevention of illness or injury in, individuals.
21 "(3) CONFLICT OF INTEREST.—The term 'con-
22 flict of interest' means an association, including a fi-
23 nancial or personal association, that have the poten-
24 tial to bias or have the appearance of biasing an in-

1 dividual's decisions in matters related to the Insti-
2 tute or the conduct of activities under this section.
3 "(4) REAL CONFLICT OF INTEREST.—The term
4 'real conflict of interest' means any instance where
5 a member of the Board, the methodology committee
6 established under subsection (d)(6), or an advisory
7 panel appointed under subsection (d)(4), or a close
8 relative of such member, has received or could re-
9 ceive either of the following:
10 "(A) A direct financial benefit of any
11 amount deriving from the result or findings of
12 a study conducted under this section.
13 "(B) A financial benefit from individuals
14 or companies that own or manufacture medical
15 treatments, services, or items to be studied
16 under this section that in the aggregate exceeds
17 $10,000 per year. For purposes of the pre-
18 ceding sentence, a financial benefit includes
19 honoraria, fees, stock, or other financial benefit
20 and the current value of the member or close
21 relative's already existing stock holdings, in ad-
22 dition to any direct financial benefit deriving
23 from the results or findings of a study con-
24 ducted under this section.

1 "(b) PATIENT-CENTERED OUTCOMES RESEARCH IN-
2 STITUTE.—
3 "(1) ESTABLISHMENT.—There is authorized to
4 be established a nonprofit corporation, to be known
5 as the 'Patient-Centered Outcomes Research Insti-
6 tute' (referred to in this section as the 'Institute')
7 which is neither an agency nor establishment of the
8 United States Government.
9 "(2) APPLICATION OF PROVISIONS.—The Insti-
10 tute shall be subject to the provisions of this section,
11 and, to the extent consistent with this section, to the
12 District of Columbia Nonprofit Corporation Act.
13 "(3) FUNDING OF COMPARATIVE CLINICAL EF-
14 FECTIVENESS RESEARCH.—For fiscal year 2010 and
15 each subsequent fiscal year, amounts in the Patient-
16 Centered Outcomes Research Trust Fund (referred
17 to in this section as the 'PCORTF') under section
18 9511 of the Internal Revenue Code of 1986 shall be
19 available, without further appropriation, to the Insti-
20 tute to carry out this section.
21 "(c) PURPOSE.—The purpose of the Institute is to
22 assist patients, clinicians, purchasers, and policy-makers
23 in making informed health decisions by advancing the
24 quality and relevance of evidence concerning the manner
25 in which diseases, disorders, and other health conditions

can effectively and appropriately be prevented, diagnosed, treated, monitored, and managed through research and evidence synthesis that considers variations in patient subpopulations, and the dissemination of research findings with respect to the relative health outcomes, clinical effectiveness, and appropriateness of the medical treatments, services, and items described in subsection (a)(2)(B).

"(d) DUTIES.—

"(1) IDENTIFYING RESEARCH PRIORITIES AND ESTABLISHING RESEARCH PROJECT AGENDA.—

"(A) IDENTIFYING RESEARCH PRIORITIES.—The Institute shall identify national priorities for research, taking into account factors of disease incidence, prevalence, and burden in the United States (with emphasis on chronic conditions), gaps in evidence in terms of clinical outcomes, practice variations and health disparities in terms of delivery and outcomes of care, the potential for new evidence to improve patient health, well-being, and the quality of care, the effect on national expenditures associated with a health care treatment, strategy, or health conditions, as well as patient needs, outcomes, and preferences, the relevance to patients and clinicians in making informed health

decisions, and priorities in the National Strategy for quality care established under section 399H of the Public Health Service Act that are consistent with this section.

"(B) ESTABLISHING RESEARCH PROJECT AGENDA.—The Institute shall establish and update a research project agenda for research to address the priorities identified under subparagraph (A), taking into consideration the types of research that might address each priority and the relative value (determined based on the cost of conducting research compared to the potential usefulness of the information produced by research) associated with the different types of research, and such other factors as the Institute determines appropriate.

"(2) CARRYING OUT RESEARCH PROJECT AGENDA.—

"(A) RESEARCH.—The Institute shall carry out the research project agenda established under paragraph (1)(B) in accordance with the methodological standards adopted under paragraph (9) using methods, including the following:

"(i) Systematic reviews and assessments of existing and future research and evidence including original research conducted subsequent to the date of the enactment of this section.

"(ii) Primary research, such as randomized clinical trials, molecularly informed trials, and observational studies.

"(iii) Any other methodologies recommended by the methodology committee established under paragraph (6) that are adopted by the Board under paragraph (9).

"(B) CONTRACTS FOR THE MANAGEMENT OF FUNDING AND CONDUCT OF RESEARCH.—

"(i) CONTRACTS.—

"(I) IN GENERAL.—In accordance with the research project agenda established under paragraph (1)(B), the Institute shall enter into contracts for the management of funding and conduct of research in accordance with the following:

"(aa) Appropriate agencies and instrumentalities of the Federal Government.

"(bb) Appropriate academic research, private sector research, or study-conducting entities.

"(II) PREFERENCE.—In entering into contracts under subclause (I), the Institute shall give preference to the Agency for Healthcare Research and Quality and the National Institutes of Health, but only if the research to be conducted or managed under such contract is authorized by the governing statutes of such Agency or Institutes.

"(ii) CONDITIONS FOR CONTRACTS.—A contract entered into under this subparagraph shall require that the agency, instrumentality, or other entity—

"(I) abide by the transparency and conflicts of interest requirements under subsection (h) that apply to the Institute with respect to the research

managed or conducted under such contract;

"(II) comply with the methodological standards adopted under paragraph (9) with respect to such research;

"(III) consult with the expert advisory panels for clinical trials and rare disease appointed under clauses (ii) and (iii), respectively, of paragraph (4)(A);

"(IV) subject to clause (iv), permit a researcher who conducts original research under the contract for the agency, instrumentality, or other entity to have such research published in a peer-reviewed journal or other publication;

"(V) have appropriate processes in place to manage data privacy and meet ethical standards for the research;

"(VI) comply with the requirements of the Institute for making the

information available to the public under paragraph (8); and

"(VII) comply with other terms and conditions determined necessary by the Institute to carry out the research agenda adopted under paragraph (2).

"(iii) COVERAGE OF COPAYMENTS OR COINSURANCE.—A contract entered into under this subparagraph may allow for the coverage of copayments or coinsurance, or allow for other appropriate measures, to the extent that such coverage or other measures are necessary to preserve the validity of a research project, such as in the case where the research project must be blinded.

"(iv) REQUIREMENTS FOR PUBLICATION OF RESEARCH.—Any research published under clause (ii)(IV) shall be within the bounds of and entirely consistent with the evidence and findings produced under the contract with the Institute under this subparagraph. If the Institute determines that those requirements are not met, the

1 Institute shall not enter into another con-
2 tract with the agency, instrumentality, or
3 entity which managed or conducted such
4 research for a period determined appro-
5 priate by the Institute (but not less than
6 5 years).

7 "(C) REVIEW AND UPDATE OF EVI-
8 DENCE.—The Institute shall review and update
9 evidence on a periodic basis as appropriate.

10 "(D) TAKING INTO ACCOUNT POTENTIAL
11 DIFFERENCES.—Research shall be designed, as
12 appropriate, to take into account the potential
13 for differences in the effectiveness of health
14 care treatments, services, and items as used
15 with various subpopulations, such as racial and
16 ethnic minorities, women, age, and groups of
17 individuals with different comorbidities, genetic
18 and molecular sub-types, or quality of life pref-
19 erences and include members of such sub-
20 populations as subjects in the research as fea-
21 sible and appropriate.

22 "(E) DIFFERENCES IN TREATMENT MO-
23 DALITIES.—Research shall be designed, as ap-
24 propriate, to take into account different charac-
25 teristics of treatment modalities that may affect

research outcomes, such as the phase of the treatment modality in the innovation cycle and the impact of the skill of the operator of the treatment modality.

"(3) DATA COLLECTION.—

"(A) IN GENERAL.—The Secretary shall, with appropriate safeguards for privacy, make available to the Institute such data collected by the Centers for Medicare & Medicaid Services under the programs under titles XVIII, XIX, and XXI, as well as provide access to the data networks developed under section 937(f) of the Public Health Service Act, as the Institute and its contractors may require to carry out this section. The Institute may also request and obtain data from Federal, State, or private entities, including data from clinical databases and registries.

"(B) USE OF DATA.—The Institute shall only use data provided to the Institute under subparagraph (A) in accordance with laws and regulations governing the release and use of such data, including applicable confidentiality and privacy standards.

"(4) APPOINTING EXPERT ADVISORY PANELS.—

"(A) APPOINTMENT.—

"(i) IN GENERAL.—The Institute may appoint permanent or ad hoc expert advisory panels as determined appropriate to assist in identifying research priorities and establishing the research project agenda under paragraph (1) and for other purposes.

"(ii) EXPERT ADVISORY PANELS FOR CLINICAL TRIALS.—The Institute shall appoint expert advisory panels in carrying out randomized clinical trials under the research project agenda under paragraph (2)(A)(ii). Such expert advisory panels shall advise the Institute and the agency, instrumentality, or entity conducting the research on the research question involved and the research design or protocol, including important patient subgroups and other parameters of the research. Such panels shall be available as a resource for technical questions that may arise during the conduct of such research.

"(iii) EXPERT ADVISORY PANEL FOR RARE DISEASE.—In the case of a research

1 study for rare disease, the Institute shall
2 appoint an expert advisory panel for pur-
3 poses of assisting in the design of the re-
4 search study and determining the relative
5 value and feasibility of conducting the re-
6 search study.

7 "(B) COMPOSITION.—An expert advisory
8 panel appointed under subparagraph (A) shall
9 include representatives of practicing and re-
10 search clinicians, patients, and experts in sci-
11 entific and health services research, health serv-
12 ices delivery, and evidence-based medicine who
13 have experience in the relevant topic, and as ap-
14 propriate, experts in integrative health and pri-
15 mary prevention strategies. The Institute may
16 include a technical expert of each manufacturer
17 or each medical technology that is included
18 under the relevant topic, project, or category
19 for which the panel is established.

20 "(5) SUPPORTING PATIENT AND CONSUMER
21 REPRESENTATIVES.—The Institute shall provide
22 support and resources to help patient and consumer
23 representatives effectively participate on the Board
24 and expert advisory panels appointed by the Insti-
25 tute under paragraph (4).

"(6) ESTABLISHING METHODOLOGY COMMITTEE.—

"(A) IN GENERAL.—The Institute shall establish a standing methodology committee to carry out the functions described in subparagraph (C).

"(B) APPOINTMENT AND COMPOSITION.—The methodology committee established under subparagraph (A) shall be composed of not more than 15 members appointed by the Comptroller General of the United States. Members appointed to the methodology committee shall be experts in their scientific field, such as health services research, clinical research, comparative clinical effectiveness research, biostatistics, genomics, and research methodologies. Stakeholders with such expertise may be appointed to the methodology committee. In addition to the members appointed under the first sentence, the Directors of the National Institutes of Health and the Agency for Healthcare Research and Quality (or their designees) shall each be included as members of the methodology committee.

"(C) FUNCTIONS.—Subject to subparagraph (D), the methodology committee shall work to develop and improve the science and methods of comparative clinical effectiveness research by, not later than 18 months after the establishment of the Institute, directly or through subcontract, developing and periodically updating the following:

"(i) Methodological standards for research. Such methodological standards shall provide specific criteria for internal validity, generalizability, feasibility, and timeliness of research and for health outcomes measures, risk adjustment, and other relevant aspects of research and assessment with respect to the design of research. Any methodological standards developed and updated under this subclause shall be scientifically based and include methods by which new information, data, or advances in technology are considered and incorporated into ongoing research projects by the Institute, as appropriate. The process for developing and updating such standards shall include input from

relevant experts, stakeholders, and decisionmakers, and shall provide opportunities for public comment. Such standards shall also include methods by which patient subpopulations can be accounted for and evaluated in different types of research. As appropriate, such standards shall build on existing work on methodological standards for defined categories of health interventions and for each of the major categories of comparative clinical effectiveness research methods (determined as of the date of enactment of the Patient Protection and Affordable Care Act).

''(ii) A translation table that is designed to provide guidance and act as a reference for the Board to determine research methods that are most likely to address each specific research question.

''(D) CONSULTATION AND CONDUCT OF EXAMINATIONS.—The methodology committee may consult and contract with the Institute of Medicine of the National Academies and academic, nonprofit, or other private and governmental entities with relevant expertise to carry

out activities described in subparagraph (C) and may consult with relevant stakeholders to carry out such activities.

"(E) REPORTS.—The methodology committee shall submit reports to the Board on the committee's performance of the functions described in subparagraph (C). Reports shall contain recommendations for the Institute to adopt methodological standards developed and updated by the methodology committee as well as other actions deemed necessary to comply with such methodological standards.

"(7) PROVIDING FOR A PEER-REVIEW PROCESS FOR PRIMARY RESEARCH.—

"(A) IN GENERAL.—The Institute shall ensure that there is a process for peer review of primary research described in subparagraph (A)(ii) of paragraph (2) that is conducted under such paragraph. Under such process—

"(i) evidence from such primary research shall be reviewed to assess scientific integrity and adherence to methodological standards adopted under paragraph (9); and

"(ii) a list of the names of individuals contributing to any peer-review process during the preceding year or years shall be made public and included in annual reports in accordance with paragraph (10)(D).

"(B) COMPOSITION.—Such peer-review process shall be designed in a manner so as to avoid bias and conflicts of interest on the part of the reviewers and shall be composed of experts in the scientific field relevant to the research under review.

"(C) USE OF EXISTING PROCESSES.—

"(i) PROCESSES OF ANOTHER ENTITY.—In the case where the Institute enters into a contract or other agreement with another entity for the conduct or management of research under this section, the Institute may utilize the peer-review process of such entity if such process meets the requirements under subparagraphs (A) and (B).

"(ii) PROCESSES OF APPROPRIATE MEDICAL JOURNALS.—The Institute may utilize the peer-review process of appropriate medical journals if such process

meets the requirements under subparagraphs (A) and (B).

"(8) RELEASE OF RESEARCH FINDINGS.—

"(A) IN GENERAL.—The Institute shall, not later than 90 days after the conduct or receipt of research findings under this part, make such research findings available to clinicians, patients, and the general public. The Institute shall ensure that the research findings—

"(i) convey the findings of research in a manner that is comprehensible and useful to patients and providers in making health care decisions;

"(ii) fully convey findings and discuss considerations specific to certain subpopulations, risk factors, and comorbidities, as appropriate;

"(iii) include limitations of the research and what further research may be needed as appropriate;

"(iv) not be construed as mandates for practice guidelines, coverage recommendations, payment, or policy recommendations; and

"(v) not include any data which would violate the privacy of research participants or any confidentiality agreements made with respect to the use of data under this section.

"(B) DEFINITION OF RESEARCH FINDINGS.—In this paragraph, the term 'research findings' means the results of a study or assessment.

"(9) ADOPTION.—Subject to subsection (h)(1), the Institute shall adopt the national priorities identified under paragraph (1)(A), the research project agenda established under paragraph (1)(B), the methodological standards developed and updated by the methodology committee under paragraph (6)(C)(i), and any peer-review process provided under paragraph (7) by majority vote. In the case where the Institute does not adopt such processes in accordance with the preceding sentence, the processes shall be referred to the appropriate staff or entity within the Institute (or, in the case of the methodological standards, the methodology committee) for further review.

"(10) ANNUAL REPORTS.—The Institute shall submit an annual report to Congress and the Presi-

dent, and shall make the annual report available to the public. Such report shall contain—

"(A) a description of the activities conducted under this section, research priorities identified under paragraph (1)(A) and methodological standards developed and updated by the methodology committee under paragraph (6)(C)(i) that are adopted under paragraph (9) during the preceding year;

"(B) the research project agenda and budget of the Institute for the following year;

"(C) any administrative activities conducted by the Institute during the preceding year;

"(D) the names of individuals contributing to any peer-review process under paragraph (7), without identifying them with a particular research project; and

"(E) any other relevant information (including information on the membership of the Board, expert advisory panels, methodology committee, and the executive staff of the Institute, any conflicts of interest with respect to these individuals, and any bylaws adopted by the Board during the preceding year).

"(e) ADMINISTRATION.—

"(1) IN GENERAL.—Subject to paragraph (2), the Board shall carry out the duties of the Institute.

"(2) NONDELEGABLE DUTIES.—The activities described in subsections (d)(1) and (d)(9) are nondelegable.

"(f) BOARD OF GOVERNORS.—

"(1) IN GENERAL.—The Institute shall have a Board of Governors, which shall consist of the following members:

"(A) The Director of Agency for Healthcare Research and Quality (or the Director's designee).

"(B) The Director of the National Institutes of Health (or the Director's designee).

"(C) Seventeen members appointed, not later than 6 months after the date of enactment of this section, by the Comptroller General of the United States as follows:

"(i) 3 members representing patients and health care consumers.

"(ii) 5 members representing physicians and providers, including at least 1 surgeon, nurse, State-licensed integrative

1 health care practitioner, and representative
2 of a hospital.
3 "(iii) 3 members representing private
4 payers, of whom at least 1 member shall
5 represent health insurance issuers and at
6 least 1 member shall represent employers
7 who self-insure employee benefits.
8 "(iv) 3 members representing pharma-
9 ceutical, device, and diagnostic manufac-
10 turers or developers.
11 "(v) 1 member representing quality
12 improvement or independent health service
13 researchers.
14 "(vi) 2 members representing the
15 Federal Government or the States, includ-
16 ing at least 1 member representing a Fed-
17 eral health program or agency.
18 "(2) QUALIFICATIONS.—The Board shall rep-
19 resent a broad range of perspectives and collectively
20 have scientific expertise in clinical health sciences re-
21 search, including epidemiology, decisions sciences,
22 health economics, and statistics. In appointing the
23 Board, the Comptroller General of the United States
24 shall consider and disclose any conflicts of interest
25 in accordance with subsection (h)(4)(B). Members of

the Board shall be recused from relevant Institute activities in the case where the member (or an immediate family member of such member) has a real conflict of interest directly related to the research project or the matter that could affect or be affected by such participation.

"(3) TERMS; VACANCIES.—A member of the Board shall be appointed for a term of 6 years, except with respect to the members first appointed, whose terms of appointment shall be staggered evenly over 2-year increments. No individual shall be appointed to the Board for more than 2 terms. Vacancies shall be filled in the same manner as the original appointment was made.

"(4) CHAIRPERSON AND VICE-CHAIRPERSON.—The Comptroller General of the United States shall designate a Chairperson and Vice Chairperson of the Board from among the members of the Board. Such members shall serve as Chairperson or Vice Chairperson for a period of 3 years.

"(5) COMPENSATION.—Each member of the Board who is not an officer or employee of the Federal Government shall be entitled to compensation (equivalent to the rate provided for level IV of the Executive Schedule under section 5315 of title 5,

United States Code) and expenses incurred while performing the duties of the Board. An officer or employee of the Federal government who is a member of the Board shall be exempt from compensation.

"(6) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—The Board may employ and fix the compensation of an Executive Director and such other personnel as may be necessary to carry out the duties of the Institute and may seek such assistance and support of, or contract with, experts and consultants that may be necessary for the performance of the duties of the Institute.

"(7) MEETINGS AND HEARINGS.—The Board shall meet and hold hearings at the call of the Chairperson or a majority of its members. Meetings not solely concerning matters of personnel shall be advertised at least 7 days in advance and open to the public. A majority of the Board members shall constitute a quorum, but a lesser number of members may meet and hold hearings.

"(g) FINANCIAL AND GOVERNMENTAL OVERSIGHT.—

"(1) CONTRACT FOR AUDIT.—The Institute shall provide for the conduct of financial audits of

the Institute on an annual basis by a private entity with expertise in conducting financial audits.

"(2) REVIEW AND ANNUAL REPORTS.—

"(A) REVIEW.—The Comptroller General of the United States shall review the following:

"(i) Not less frequently than on an annual basis, the financial audits conducted under paragraph (1).

"(ii) Not less frequently than every 5 years, the processes established by the Institute, including the research priorities and the conduct of research projects, in order to determine whether information produced by such research projects is objective and credible, is produced in a manner consistent with the requirements under this section, and is developed through a transparent process.

"(iii) Not less frequently than every 5 years, the dissemination and training activities and data networks established under section 937 of the Public Health Service Act, including the methods and products used to disseminate research, the types of training conducted and supported,

and the types and functions of the data networks established, in order to determine whether the activities and data are produced in a manner consistent with the requirements under such section.

"(iv) Not less frequently than every 5 years, the overall effectiveness of activities conducted under this section and the dissemination, training, and capacity building activities conducted under section 937 of the Public Health Service Act. Such review shall include an analysis of the extent to which research findings are used by health care decision-makers, the effect of the dissemination of such findings on reducing practice variation and disparities in health care, and the effect of the research conducted and disseminated on innovation and the health care economy of the United States.

"(v) Not later than 8 years after the date of enactment of this section, the adequacy and use of the funding for the Institute and the activities conducted under section 937 of the Public Health Service

Act, including a determination as to whether, based on the utilization of research findings by public and private payers, funding sources for the Patient-Centered Outcomes Research Trust Fund under section 9511 of the Internal Revenue Code of 1986 are appropriate and whether such sources of funding should be continued or adjusted.

"(B) ANNUAL REPORTS.—Not later than April 1 of each year, the Comptroller General of the United States shall submit to Congress a report containing the results of the review conducted under subparagraph (A) with respect to the preceding year (or years, if applicable), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

"(h) ENSURING TRANSPARENCY, CREDIBILITY, AND ACCESS.—The Institute shall establish procedures to ensure that the following requirements for ensuring transparency, credibility, and access are met:

"(1) PUBLIC COMMENT PERIODS.—The Institute shall provide for a public comment period of not less than 45 days and not more than 60 days prior

to the adoption under subsection (d)(9) of the national priorities identified under subsection (d)(1)(A), the research project agenda established under subsection (d)(1)(B), the methodological standards developed and updated by the methodology committee under subsection (d)(6)(C)(i), and the peer-review process provided under paragraph (7), and after the release of draft findings with respect to systematic reviews of existing research and evidence.

''(2) ADDITIONAL FORUMS.—The Institute shall support forums to increase public awareness and obtain and incorporate public input and feedback through media (such as an Internet website) on research priorities, research findings, and other duties, activities, or processes the Institute determines appropriate.

''(3) PUBLIC AVAILABILITY.—The Institute shall make available to the public and disclose through the official public Internet website of the Institute the following:

''(A) Information contained in research findings as specified in subsection (d)(9).

''(B) The process and methods for the conduct of research, including the identity of the

entity and the investigators conducing such research and any conflicts of interests of such parties, any direct or indirect links the entity has to industry, and research protocols, including measures taken, methods of research and analysis, research results, and such other information the Institute determines appropriate) concurrent with the release of research findings.

"(C) Notice of public comment periods under paragraph (1), including deadlines for public comments.

"(D) Subsequent comments received during each of the public comment periods.

"(E) In accordance with applicable laws and processes and as the Institute determines appropriate, proceedings of the Institute.

"(4) DISCLOSURE OF CONFLICTS OF INTEREST.—

"(A) IN GENERAL.—A conflict of interest shall be disclosed in the following manner:

"(i) By the Institute in appointing members to an expert advisory panel under subsection (d)(4), in selecting individuals to contribute to any peer-review process

under subsection (d)(7), and for employment as executive staff of the Institute.

"(ii) By the Comptroller General in appointing members of the methodology committee under subsection (d)(6);

"(iii) By the Institute in the annual report under subsection (d)(10), except that, in the case of individuals contributing to any such peer review process, such description shall be in a manner such that those individuals cannot be identified with a particular research project.

"(B) MANNER OF DISCLOSURE.—Conflicts of interest shall be disclosed as described in subparagraph (A) as soon as practicable on the Internet web site of the Institute and of the Government Accountability Office. The information disclosed under the preceding sentence shall include the type, nature, and magnitude of the interests of the individual involved, except to the extent that the individual recuses himself or herself from participating in the consideration of or any other activity with respect to the study as to which the potential conflict exists.

"(i) RULES.—The Institute, its Board or staff, shall be prohibited from accepting gifts, bequeaths, or donations of services or property. In addition, the Institute shall be prohibited from establishing a corporation or generating revenues from activities other than as provided under this section.

"(j) RULES OF CONSTRUCTION.—

"(1) COVERAGE.—Nothing in this section shall be construed—

"(A) to permit the Institute to mandate coverage, reimbursement, or other policies for any public or private payer; or

"(B) as preventing the Secretary from covering the routine costs of clinical care received by an individual entitled to, or enrolled for, benefits under title XVIII, XIX, or XXI in the case where such individual is participating in a clinical trial and such costs would otherwise be covered under such title with respect to the beneficiary.".

(b) DISSEMINATION AND BUILDING CAPACITY FOR RESEARCH.—Title IX of the Public Health Service Act (42 U.S.C. 299 et seq.), as amended by section 3606, is further amended by inserting after section 936 the following:

"SEC. 937. DISSEMINATION AND BUILDING CAPACITY FOR RESEARCH.

"(a) IN GENERAL.—

"(1) DISSEMINATION.—The Office of Communication and Knowledge Transfer (referred to in this section as the 'Office') at the Agency for Healthcare Research and Quality (or any other relevant office designated by Agency for Healthcare Research and Quality), in consultation with the National Institutes of Health, shall broadly disseminate the research findings that are published by the Patient Centered Outcomes Research Institute established under section 1181(b) of the Social Security Act (referred to in this section as the 'Institute') and other government-funded research relevant to comparative clinical effectiveness research. The Office shall create informational tools that organize and disseminate research findings for physicians, health care providers, patients, payers, and policy makers. The Office shall also develop a publicly available resource database that collects and contains government-funded evidence and research from public, private, not-for profit, and academic sources.

"(2) REQUIREMENTS.—The Office shall provide for the dissemination of the Institute's research findings and government-funded research relevant to

comparative clinical effectiveness research to physicians, health care providers, patients, vendors of health information technology focused on clinical decision support, appropriate professional associations, and Federal and private health plans. Materials, forums, and media used to disseminate the findings, informational tools, and resource databases shall—

"(A) include a description of considerations for specific subpopulations, the research methodology, and the limitations of the research, and the names of the entities, agencies, instrumentalities, and individuals who conducted any research which was published by the Institute; and

"(B) not be construed as mandates, guidelines, or recommendations for payment, coverage, or treatment.

"(b) INCORPORATION OF RESEARCH FINDINGS.—The Office, in consultation with relevant medical and clinical associations, shall assist users of health information technology focused on clinical decision support to promote the timely incorporation of research findings disseminated under subsection (a) into clinical practices and to promote the ease of use of such incorporation.

1 "(c) FEEDBACK.—The Office shall establish a proc-
2 ess to receive feedback from physicians, health care pro-
3 viders, patients, and vendors of health information tech-
4 nology focused on clinical decision support, appropriate
5 professional associations, and Federal and private health
6 plans about the value of the information disseminated and
7 the assistance provided under this section.

8 "(d) RULE OF CONSTRUCTION.—Nothing in this sec-
9 tion shall preclude the Institute from making its research
10 findings publicly available as required under section
11 1181(d)(8) of the Social Security Act.

12 "(e) TRAINING OF RESEARCHERS.—The Agency for
13 Health Care Research and Quality, in consultation with
14 the National Institutes of Health, shall build capacity for
15 comparative clinical effectiveness research by establishing
16 a grant program that provides for the training of research-
17 ers in the methods used to conduct such research, includ-
18 ing systematic reviews of existing research and primary
19 research such as clinical trials. At a minimum, such train-
20 ing shall be in methods that meet the methodological
21 standards adopted under section 1181(d)(9) of the Social
22 Security Act.

23 "(f) BUILDING DATA FOR RESEARCH.—The Sec-
24 retary shall provide for the coordination of relevant Fed-
25 eral health programs to build data capacity for compara-

1 tive clinical effectiveness research, including the develop-
2 ment and use of clinical registries and health outcomes
3 research data networks, in order to develop and maintain
4 a comprehensive, interoperable data network to collect,
5 link, and analyze data on outcomes and effectiveness from
6 multiple sources, including electronic health records.

7 ''(g) AUTHORITY TO CONTRACT WITH THE INSTI-
8 TUTE.—Agencies and instrumentalities of the Federal
9 Government may enter into agreements with the Institute,
10 and accept and retain funds, for the conduct and support
11 of research described in this part, provided that the re-
12 search to be conducted or supported under such agree-
13 ments is authorized under the governing statutes of such
14 agencies and instrumentalities.''.

15 (c) IN GENERAL.—Part D of title XI of the Social
16 Security Act, as added by subsection (a), is amended by
17 adding at the end the following new section:

18 ''LIMITATIONS ON CERTAIN USES OF COMPARATIVE
19 CLINICAL EFFECTIVENESS RESEARCH

20 ''SEC. 1182. (a) The Secretary may only use evidence
21 and findings from research conducted under section 1181
22 to make a determination regarding coverage under title
23 XVIII if such use is through an iterative and transparent
24 process which includes public comment and considers the
25 effect on subpopulations.

26 ''(b) Nothing in section 1181 shall be construed as—

1 "(1) superceding or modifying the coverage of
2 items or services under title XVIII that the Sec-
3 retary determines are reasonable and necessary
4 under section 1862(l)(1); or
5 "(2) authorizing the Secretary to deny coverage
6 of items or services under such title solely on the
7 basis of comparative clinical effectiveness research.
8 "(c)(1) The Secretary shall not use evidence or find-
9 ings from comparative clinical effectiveness research con-
10 ducted under section 1181 in determining coverage, reim-
11 bursement, or incentive programs under title XVIII in a
12 manner that treats extending the life of an elderly, dis-
13 abled, or terminally ill individual as of lower value than
14 extending the life of an individual who is younger, non-
15 disabled, or not terminally ill.
16 "(2) Paragraph (1) shall not be construed as pre-
17 venting the Secretary from using evidence or findings from
18 such comparative clinical effectiveness research in deter-
19 mining coverage, reimbursement, or incentive programs
20 under title XVIII based upon a comparison of the dif-
21 ference in the effectiveness of alternative treatments in ex-
22 tending an individual's life due to the individual's age, dis-
23 ability, or terminal illness.
24 "(d)(1) The Secretary shall not use evidence or find-
25 ings from comparative clinical effectiveness research con-

1 ducted under section 1181 in determining coverage, reim-
2 bursement, or incentive programs under title XVIII in a
3 manner that precludes, or with the intent to discourage,
4 an individual from choosing a health care treatment based
5 on how the individual values the tradeoff between extend-
6 ing the length of their life and the risk of disability.

7 ''(2)(A) Paragraph (1) shall not be construed to—

8 ''(i) limit the application of differential copay-
9 ments under title XVIII based on factors such as
10 cost or type of service; or

11 ''(ii) prevent the Secretary from using evidence
12 or findings from such comparative clinical effective-
13 ness research in determining coverage, reimburse-
14 ment, or incentive programs under such title based
15 upon a comparison of the difference in the effective-
16 ness of alternative health care treatments in extend-
17 ing an individual's life due to that individual's age,
18 disability, or terminal illness.

19 ''(3) Nothing in the provisions of, or amendments
20 made by the Patient Protection and Affordable Care Act,
21 shall be construed to limit comparative clinical effective-
22 ness research or any other research, evaluation, or dis-
23 semination of information concerning the likelihood that
24 a health care treatment will result in disability.

1 "(e) The Patient-Centered Outcomes Research Insti-
2 tute established under section 1181(b)(1) shall not develop
3 or employ a dollars-per-quality adjusted life year (or simi-
4 lar measure that discounts the value of a life because of
5 an individual's disability) as a threshold to establish what
6 type of health care is cost effective or recommended. The
7 Secretary shall not utilize such an adjusted life year (or
8 such a similar measure) as a threshold to determine cov-
9 erage, reimbursement, or incentive programs under title
10 XVIII.".

11 (d) IN GENERAL.—Part D of title XI of the Social
12 Security Act, as added by subsection (a) and amended by
13 subsection (c), is amended by adding at the end the fol-
14 lowing new section:

15 "TRUST FUND TRANSFERS TO PATIENT-CENTERED
16 OUTCOMES RESEARCH TRUST FUND

17 "SEC. 1183. (a) IN GENERAL.—The Secretary shall
18 provide for the transfer, from the Federal Hospital Insur-
19 ance Trust Fund under section 1817 and the Federal Sup-
20 plementary Medical Insurance Trust Fund under section
21 1841, in proportion (as estimated by the Secretary) to the
22 total expenditures during such fiscal year that are made
23 under title XVIII from the respective trust fund, to the
24 Patient-Centered Outcomes Research Trust Fund (re-
25 ferred to in this section as the 'PCORTF') under section

9511 of the Internal Revenue Code of 1986, of the following:

"(1) For fiscal year 2013, an amount equal to $1 multiplied by the average number of individuals entitled to benefits under part A, or enrolled under part B, of title XVIII during such fiscal year.

"(2) For each of fiscal years 2014, 2015, 2016, 2017, 2018, and 2019, an amount equal to $2 multiplied by the average number of individuals entitled to benefits under part A, or enrolled under part B, of title XVIII during such fiscal year.

"(b) ADJUSTMENTS FOR INCREASES IN HEALTH CARE SPENDING.—In the case of any fiscal year beginning after September 30, 2014, the dollar amount in effect under subsection (a)(2) for such fiscal year shall be equal to the sum of such dollar amount for the previous fiscal year (determined after the application of this subsection), plus an amount equal to the product of—

"(1) such dollar amount for the previous fiscal year, multiplied by

"(2) the percentage increase in the projected per capita amount of National Health Expenditures, as most recently published by the Secretary before the beginning of the fiscal year.".

(e) PATIENT-CENTERED OUTCOMES RESEARCH TRUST FUND; FINANCING FOR TRUST FUND.—

(1) ESTABLISHMENT OF TRUST FUND.—

(A) IN GENERAL.—Subchapter A of chapter 98 of the Internal Revenue Code of 1986 (relating to establishment of trust funds) is amended by adding at the end the following new section:

"SEC. 9511. PATIENT-CENTERED OUTCOMES RESEARCH TRUST FUND.

"(a) CREATION OF TRUST FUND.—There is established in the Treasury of the United States a trust fund to be known as the 'Patient-Centered Outcomes Research Trust Fund' (hereafter in this section referred to as the 'PCORTF'), consisting of such amounts as may be appropriated or credited to such Trust Fund as provided in this section and section 9602(b).

"(b) TRANSFERS TO FUND.—

"(1) APPROPRIATION.—There are hereby appropriated to the Trust Fund the following:

"(A) For fiscal year 2010, $10,000,000.

"(B) For fiscal year 2011, $50,000,000.

"(C) For fiscal year 2012, $150,000,000.

"(D) For fiscal year 2013—

"(i) an amount equivalent to the net revenues received in the Treasury from the fees imposed under subchapter B of chapter 34 (relating to fees on health insurance and self-insured plans) for such fiscal year; and

"(ii) $150,000,000.

"(E) For each of fiscal years 2014, 2015, 2016, 2017, 2018, and 2019—

"(i) an amount equivalent to the net revenues received in the Treasury from the fees imposed under subchapter B of chapter 34 (relating to fees on health insurance and self-insured plans) for such fiscal year; and

"(ii) $150,000,000.

The amounts appropriated under subparagraphs (A), (B), (C), (D)(ii), and (E)(ii) shall be transferred from the general fund of the Treasury, from funds not otherwise appropriated.

"(2) TRUST FUND TRANSFERS.—In addition to the amounts appropriated under paragraph (1), there shall be credited to the PCORTF the amounts

1 transferred under section 1183 of the Social Secu-
2 rity Act.
3 "(3) LIMITATION ON TRANSFERS TO PCORTF.—
4 No amount may be appropriated or transferred to
5 the PCORTF on and after the date of any expendi-
6 ture from the PCORTF which is not an expenditure
7 permitted under this section. The determination of
8 whether an expenditure is so permitted shall be
9 made without regard to—
10 "(A) any provision of law which is not con-
11 tained or referenced in this chapter or in a rev-
12 enue Act, and
13 "(B) whether such provision of law is a
14 subsequently enacted provision or directly or in-
15 directly seeks to waive the application of this
16 paragraph.
17 "(c) TRUSTEE.—The Secretary of the Treasury shall
18 be a trustee of the PCORTF.
19 "(d) EXPENDITURES FROM FUND.—
20 "(1) AMOUNTS AVAILABLE TO THE PATIENT-
21 CENTERED OUTCOMES RESEARCH INSTITUTE.—Sub-
22 ject to paragraph (2), amounts in the PCORTF are
23 available, without further appropriation, to the Pa-
24 tient-Centered Outcomes Research Institute estab-
25 lished under section 1181(b) of the Social Security

Act for carrying out part D of title XI of the Social Security Act (as in effect on the date of enactment of such Act).

"(2) TRANSFER OF FUNDS.—

"(A) IN GENERAL.—The trustee of the PCORTF shall provide for the transfer from the PCORTF of 20 percent of the amounts appropriated or credited to the PCORTF for each of fiscal years 2011 through 2019 to the Secretary of Health and Human Services to carry out section 937 of the Public Health Service Act.

"(B) AVAILABILITY.—Amounts transferred under subparagraph (A) shall remain available until expended.

"(C) REQUIREMENTS.—Of the amounts transferred under subparagraph (A) with respect to a fiscal year, the Secretary of Health and Human Services shall distribute—

"(i) 80 percent to the Office of Communication and Knowledge Transfer of the Agency for Healthcare Research and Quality (or any other relevant office designated by Agency for Healthcare Research and Quality) to carry out the activities de-

1 scribed in section 937 of the Public Health
2 Service Act; and
3 ''(ii) 20 percent to the Secretary to
4 carry out the activities described in such
5 section 937.
6 ''(e) NET REVENUES.—For purposes of this section,
7 the term 'net revenues' means the amount estimated by
8 the Secretary of the Treasury based on the excess of—
9 ''(1) the fees received in the Treasury under
10 subchapter B of chapter 34, over
11 ''(2) the decrease in the tax imposed by chapter
12 1 resulting from the fees imposed by such sub-
13 chapter.
14 ''(f) TERMINATION.—No amounts shall be available
15 for expenditure from the PCORTF after September 30,
16 2019, and any amounts in such Trust Fund after such
17 date shall be transferred to the general fund of the Treas-
18 ury.''.
19 (B) CLERICAL AMENDMENT.—The table of
20 sections for subchapter A of chapter 98 of such
21 Code is amended by adding at the end the fol-
22 lowing new item:

''Sec. 9511. Patient-centered outcomes research trust fund.''.

23 (2) FINANCING FOR FUND FROM FEES ON IN-
24 SURED AND SELF-INSURED HEALTH PLANS.—

(A) GENERAL RULE.—Chapter 34 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subchapter:

"Subchapter B—Insured and Self-Insured Health Plans

"Sec. 4375. Health insurance.
"Sec. 4376. Self-insured health plans.
"Sec. 4377. Definitions and special rules.

"SEC. 4375. HEALTH INSURANCE.

"(a) IMPOSITION OF FEE.—There is hereby imposed on each specified health insurance policy for each policy year ending after September 30, 2012, a fee equal to the product of $2 ($1 in the case of policy years ending during fiscal year 2013) multiplied by the average number of lives covered under the policy.

"(b) LIABILITY FOR FEE.—The fee imposed by subsection (a) shall be paid by the issuer of the policy.

"(c) SPECIFIED HEALTH INSURANCE POLICY.—For purposes of this section:

"(1) IN GENERAL.—Except as otherwise provided in this section, the term 'specified health insurance policy' means any accident or health insurance policy (including a policy under a group health plan) issued with respect to individuals residing in the United States.

"(2) EXEMPTION FOR CERTAIN POLICIES.—The term 'specified health insurance policy' does not in-

1 clude any insurance if substantially all of its cov-
2 erage is of excepted benefits described in section
3 9832(c).

4 "(3) TREATMENT OF PREPAID HEALTH COV-
5 ERAGE ARRANGEMENTS.—

6 "(A) IN GENERAL.—In the case of any ar-
7 rangement described in subparagraph (B), such
8 arrangement shall be treated as a specified
9 health insurance policy, and the person referred
10 to in such subparagraph shall be treated as the
11 issuer.

12 "(B) DESCRIPTION OF ARRANGEMENTS.—
13 An arrangement is described in this subpara-
14 graph if under such arrangement fixed pay-
15 ments or premiums are received as consider-
16 ation for any person's agreement to provide or
17 arrange for the provision of accident or health
18 coverage to residents of the United States, re-
19 gardless of how such coverage is provided or ar-
20 ranged to be provided.

21 "(d) ADJUSTMENTS FOR INCREASES IN HEALTH
22 CARE SPENDING.—In the case of any policy year ending
23 in any fiscal year beginning after September 30, 2014, the
24 dollar amount in effect under subsection (a) for such pol-
25 icy year shall be equal to the sum of such dollar amount

1 for policy years ending in the previous fiscal year (deter-
2 mined after the application of this subsection), plus an
3 amount equal to the product of—

4 ''(1) such dollar amount for policy years ending
5 in the previous fiscal year, multiplied by

6 ''(2) the percentage increase in the projected
7 per capita amount of National Health Expenditures,
8 as most recently published by the Secretary before
9 the beginning of the fiscal year.

10 ''(e) TERMINATION.—This section shall not apply to
11 policy years ending after September 30, 2019.

12 **''SEC. 4376. SELF-INSURED HEALTH PLANS.**

13 ''(a) IMPOSITION OF FEE.—In the case of any appli-
14 cable self-insured health plan for each plan year ending
15 after September 30, 2012, there is hereby imposed a fee
16 equal to $2 ($1 in the case of plan years ending during
17 fiscal year 2013) multiplied by the average number of lives
18 covered under the plan.

19 ''(b) LIABILITY FOR FEE.—

20 ''(1) IN GENERAL.—The fee imposed by sub-
21 section (a) shall be paid by the plan sponsor.

22 ''(2) PLAN SPONSOR.—For purposes of para-
23 graph (1) the term 'plan sponsor' means—

24 ''(A) the employer in the case of a plan es-
25 tablished or maintained by a single employer,

"(B) the employee organization in the case of a plan established or maintained by an employee organization,

"(C) in the case of—

"(i) a plan established or maintained by 2 or more employers or jointly by 1 or more employers and 1 or more employee organizations,

"(ii) a multiple employer welfare arrangement, or

"(iii) a voluntary employees' beneficiary association described in section 501(c)(9),the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan, or

"(D) the cooperative or association described in subsection (c)(2)(F) in the case of a plan established or maintained by such a cooperative or association.

"(c) APPLICABLE SELF-INSURED HEALTH PLAN.—For purposes of this section, the term 'applicable self-insured health plan' means any plan for providing accident or health coverage if—

1 "(1) any portion of such coverage is provided
2 other than through an insurance policy, and
3 "(2) such plan is established or maintained—
4 "(A) by 1 or more employers for the ben-
5 efit of their employees or former employees,
6 "(B) by 1 or more employee organizations
7 for the benefit of their members or former
8 members,
9 "(C) jointly by 1 or more employers and 1
10 or more employee organizations for the benefit
11 of employees or former employees,
12 "(D) by a voluntary employees' beneficiary
13 association described in section 501(c)(9),
14 "(E) by any organization described in sec-
15 tion 501(c)(6), or
16 "(F) in the case of a plan not described in
17 the preceding subparagraphs, by a multiple em-
18 ployer welfare arrangement (as defined in sec-
19 tion 3(40) of Employee Retirement Income Se-
20 curity Act of 1974), a rural electric cooperative
21 (as defined in section 3(40)(B)(iv) of such Act),
22 or a rural telephone cooperative association (as
23 defined in section 3(40)(B)(v) of such Act).
24 "(d) ADJUSTMENTS FOR INCREASES IN HEALTH
25 CARE SPENDING.—In the case of any plan year ending

in any fiscal year beginning after September 30, 2014, the dollar amount in effect under subsection (a) for such plan year shall be equal to the sum of such dollar amount for plan years ending in the previous fiscal year (determined after the application of this subsection), plus an amount equal to the product of—

"(1) such dollar amount for plan years ending in the previous fiscal year, multiplied by

"(2) the percentage increase in the projected per capita amount of National Health Expenditures, as most recently published by the Secretary before the beginning of the fiscal year.

"(e) TERMINATION.—This section shall not apply to plan years ending after September 30, 2019.

"SEC. 4377. DEFINITIONS AND SPECIAL RULES.

"(a) DEFINITIONS.—For purposes of this subchapter—

"(1) ACCIDENT AND HEALTH COVERAGE.—The term 'accident and health coverage' means any coverage which, if provided by an insurance policy, would cause such policy to be a specified health insurance policy (as defined in section 4375(c)).

"(2) INSURANCE POLICY.—The term 'insurance policy' means any policy or other instrument where-

by a contract of insurance is issued, renewed, or extended.

"(3) UNITED STATES.—The term 'United States' includes any possession of the United States.

"(b) TREATMENT OF GOVERNMENTAL ENTITIES.—

"(1) IN GENERAL.—For purposes of this subchapter—

"(A) the term 'person' includes any governmental entity, and

"(B) notwithstanding any other law or rule of law, governmental entities shall not be exempt from the fees imposed by this subchapter except as provided in paragraph (2).

"(2) TREATMENT OF EXEMPT GOVERNMENTAL PROGRAMS.—In the case of an exempt governmental program, no fee shall be imposed under section 4375 or section 4376 on any covered life under such program.

"(3) EXEMPT GOVERNMENTAL PROGRAM DEFINED.—For purposes of this subchapter, the term 'exempt governmental program' means—

"(A) any insurance program established under title XVIII of the Social Security Act,

"(B) the medical assistance program established by title XIX or XXI of the Social Security Act,

"(C) any program established by Federal law for providing medical care (other than through insurance policies) to individuals (or the spouses and dependents thereof) by reason of such individuals being members of the Armed Forces of the United States or veterans, and

"(D) any program established by Federal law for providing medical care (other than through insurance policies) to members of Indian tribes (as defined in section 4(d) of the Indian Health Care Improvement Act).

"(c) TREATMENT AS TAX.—For purposes of subtitle F, the fees imposed by this subchapter shall be treated as if they were taxes.

"(d) NO COVER OVER TO POSSESSIONS.—Notwithstanding any other provision of law, no amount collected under this subchapter shall be covered over to any possession of the United States.".

(B) CLERICAL AMENDMENTS.—

(i) Chapter 34 of such Code is amended by striking the chapter heading and inserting the following:

"CHAPTER 34—TAXES ON CERTAIN INSURANCE POLICIES

"SUBCHAPTER A. POLICIES ISSUED BY FOREIGN INSURERS

"SUBCHAPTER B. INSURED AND SELF-INSURED HEALTH PLANS

"Subchapter A—Policies Issued By Foreign Insurers".

(ii) The table of chapters for subtitle D of such Code is amended by striking the item relating to chapter 34 and inserting the following new item:

"CHAPTER 34—TAXES ON CERTAIN INSURANCE POLICIES".

(f) TAX-EXEMPT STATUS OF THE PATIENT-CENTERED OUTCOMES RESEARCH INSTITUTE.—Subsection 501(l) of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:

"(4) The Patient-Centered Outcomes Research Institute established under section 1181(b) of the Social Security Act.".

SEC. 6302. FEDERAL COORDINATING COUNCIL FOR COMPARATIVE EFFECTIVENESS RESEARCH.

Notwithstanding any other provision of law, the Federal Coordinating Council for Comparative Effectiveness Research established under section 804 of Division A of

the American Recovery and Reinvestment Act of 2009 (42 U.S.C. 299b–8), including the requirement under subsection (e)(2) of such section, shall terminate on the date of enactment of this Act.

Subtitle E—Medicare, Medicaid, and CHIP Program Integrity Provisions

SEC. 6401. PROVIDER SCREENING AND OTHER ENROLLMENT REQUIREMENTS UNDER MEDICARE, MEDICAID, AND CHIP.

(a) MEDICARE.—Section 1866(j) of the Social Security Act (42 U.S.C. 1395cc(j)) is amended—

(1) in paragraph (1)(A), by adding at the end the following: ''Such process shall include screening of providers and suppliers in accordance with paragraph (2), a provisional period of enhanced oversight in accordance with paragraph (3), disclosure requirements in accordance with paragraph (4), the imposition of temporary enrollment moratoria in accordance with paragraph (5), and the establishment of compliance programs in accordance with paragraph (6).'';

(2) by redesignating paragraph (2) as paragraph (7); and

(3) by inserting after paragraph (1) the following:

"(2) PROVIDER SCREENING.—

"(A) PROCEDURES.—Not later than 180 days after the date of enactment of this paragraph, the Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall establish procedures under which screening is conducted with respect to providers of medical or other items or services and suppliers under the program under this title, the Medicaid program under title XIX, and the CHIP program under title XXI.

"(B) LEVEL OF SCREENING.—The Secretary shall determine the level of screening conducted under this paragraph according to the risk of fraud, waste, and abuse, as determined by the Secretary, with respect to the category of provider of medical or other items or services or supplier. Such screening—

"(i) shall include a licensure check, which may include such checks across States; and

"(ii) may, as the Secretary determines appropriate based on the risk of fraud,

1 waste, and abuse described in the pre-
2 ceding sentence, include—
3 "(I) a criminal background
4 check;
5 "(II) fingerprinting;
6 "(III) unscheduled and unan-
7 nounced site visits, including
8 preenrollment site visits;
9 "(IV) database checks (including
10 such checks across States); and
11 "(V) such other screening as the
12 Secretary determines appropriate.
13 "(C) APPLICATION FEES.—
14 "(i) INDIVIDUAL PROVIDERS.—Except
15 as provided in clause (iii), the Secretary
16 shall impose a fee on each individual pro-
17 vider of medical or other items or services
18 or supplier (such as a physician, physician
19 assistant, nurse practitioner, or clinical
20 nurse specialist) with respect to which
21 screening is conducted under this para-
22 graph in an amount equal to—
23 "(I) for 2010, $200; and
24 "(II) for 2011 and each subse-
25 quent year, the amount determined

1 under this clause for the preceding
2 year, adjusted by the percentage
3 change in the consumer price index
4 for all urban consumers (all items;
5 United States city average) for the
6 12-month period ending with June of
7 the previous year.
8 ''(ii) INSTITUTIONAL PROVIDERS.—
9 Except as provided in clause (iii), the Sec-
10 retary shall impose a fee on each institu-
11 tional provider of medical or other items or
12 services or supplier (such as a hospital or
13 skilled nursing facility) with respect to
14 which screening is conducted under this
15 paragraph in an amount equal to—
16 ''(I) for 2010, $500; and
17 ''(II) for 2011 and each subse-
18 quent year, the amount determined
19 under this clause for the preceding
20 year, adjusted by the percentage
21 change in the consumer price index
22 for all urban consumers (all items;
23 United States city average) for the
24 12-month period ending with June of
25 the previous year.

"(iii) HARDSHIP EXCEPTION; WAIVER FOR CERTAIN MEDICAID PROVIDERS.—The Secretary may, on a case-by-case basis, exempt a provider of medical or other items or services or supplier from the imposition of an application fee under this subparagraph if the Secretary determines that the imposition of the application fee would result in a hardship. The Secretary may waive the application fee under this subparagraph for providers enrolled in a State Medicaid program for whom the State demonstrates that imposition of the fee would impede beneficiary access to care.

"(iv) USE OF FUNDS.—Amounts collected as a result of the imposition of a fee under this subparagraph shall be used by the Secretary for program integrity efforts, including to cover the costs of conducting screening under this paragraph and to carry out this subsection and section 1128J.

"(D) APPLICATION AND ENFORCEMENT.—

"(i) NEW PROVIDERS OF SERVICES AND SUPPLIERS.—The screening under

this paragraph shall apply, in the case of a provider of medical or other items or services or supplier who is not enrolled in the program under this title, title XIX , or title XXI as of the date of enactment of this paragraph, on or after the date that is 1 year after such date of enactment.

''(ii) CURRENT PROVIDERS OF SERVICES AND SUPPLIERS.—The screening under this paragraph shall apply, in the case of a provider of medical or other items or services or supplier who is enrolled in the program under this title, title XIX, or title XXI as of such date of enactment, on or after the date that is 2 years after such date of enactment.

''(iii) REVALIDATION OF ENROLLMENT.—Effective beginning on the date that is 180 days after such date of enactment, the screening under this paragraph shall apply with respect to the revalidation of enrollment of a provider of medical or other items or services or supplier in the program under this title, title XIX, or title XXI.

1 "(iv) LIMITATION ON ENROLLMENT
2 AND REVALIDATION OF ENROLLMENT.—In
3 no case may a provider of medical or other
4 items or services or supplier who has not
5 been screened under this paragraph be ini-
6 tially enrolled or reenrolled in the program
7 under this title, title XIX, or title XXI on
8 or after the date that is 3 years after such
9 date of enactment.
10 "(E) EXPEDITED RULEMAKING.—The Sec-
11 retary may promulgate an interim final rule to
12 carry out this paragraph.
13 "(3) PROVISIONAL PERIOD OF ENHANCED
14 OVERSIGHT FOR NEW PROVIDERS OF SERVICES AND
15 SUPPLIERS.—
16 "(A) IN GENERAL.—The Secretary shall
17 establish procedures to provide for a provisional
18 period of not less than 30 days and not more
19 than 1 year during which new providers of med-
20 ical or other items or services and suppliers, as
21 the Secretary determines appropriate, including
22 categories of providers or suppliers, would be
23 subject to enhanced oversight, such as prepay-
24 ment review and payment caps, under the pro-
25 gram under this title, the Medicaid program

1 under title XIX. and the CHIP program under
2 title XXI.
3 "(B) IMPLEMENTATION.—The Secretary
4 may establish by program instruction or other-
5 wise the procedures under this paragraph.
6 "(4) INCREASED DISCLOSURE REQUIRE-
7 MENTS.—
8 "(A) DISCLOSURE.—A provider of medical
9 or other items or services or supplier who sub-
10 mits an application for enrollment or revalida-
11 tion of enrollment in the program under this
12 title , title XIX, or title XXI on or after the
13 date that is 1 year after the date of enactment
14 of this paragraph shall disclose (in a form and
15 manner and at such time as determined by the
16 Secretary) any current or previous affiliation
17 (directly or indirectly) with a provider of med-
18 ical or other items or services or supplier that
19 has uncollected debt, has been or is subject to
20 a payment suspension under a Federal health
21 care program (as defined in section 1128B(f)),
22 has been excluded from participation under the
23 program under this title, the Medicaid program
24 under title XIX, or the CHIP program under

1 title XXI, or has had its billing privileges de-
2 nied or revoked.
3 "(B) AUTHORITY TO DENY ENROLL-
4 MENT.—If the Secretary determines that such
5 previous affiliation poses an undue risk of
6 fraud, waste, or abuse, the Secretary may deny
7 such application. Such a denial shall be subject
8 to appeal in accordance with paragraph (7).
9 "(5) AUTHORITY TO ADJUST PAYMENTS OF
10 PROVIDERS OF SERVICES AND SUPPLIERS WITH THE
11 SAME TAX IDENTIFICATION NUMBER FOR PAST-DUE
12 OBLIGATIONS.—
13 "(A) IN GENERAL.—Notwithstanding any
14 other provision of this title, in the case of an
15 applicable provider of services or supplier, the
16 Secretary may make any necessary adjustments
17 to payments to the applicable provider of serv-
18 ices or supplier under the program under this
19 title in order to satisfy any past-due obligations
20 described in subparagraph (B)(ii) of an obli-
21 gated provider of services or supplier.
22 "(B) DEFINITIONS.—In this paragraph:
23 "(i) IN GENERAL.—The term 'applica-
24 ble provider of services or supplier' means
25 a provider of services or supplier that has

the same taxpayer identification number assigned under section 6109 of the Internal Revenue Code of 1986 as is assigned to the obligated provider of services or supplier under such section, regardless of whether the applicable provider of services or supplier is assigned a different billing number or national provider identification number under the program under this title than is assigned to the obligated provider of services or supplier.

"(ii) OBLIGATED PROVIDER OF SERVICES OR SUPPLIER.—The term 'obligated provider of services or supplier' means a provider of services or supplier that owes a past-due obligation under the program under this title (as determined by the Secretary).

"(6) TEMPORARY MORATORIUM ON ENROLLMENT OF NEW PROVIDERS.—

"(A) IN GENERAL.—The Secretary may impose a temporary moratorium on the enrollment of new providers of services and suppliers, including categories of providers of services and suppliers, in the program under this title, under

1 the Medicaid program under title XIX, or
2 under the CHIP program under title XXI if the
3 Secretary determines such moratorium is nec-
4 essary to prevent or combat fraud, waste, or
5 abuse under either such program.

6 "(B) LIMITATION ON REVIEW.—There
7 shall be no judicial review under section 1869,
8 section 1878, or otherwise, of a temporary mor-
9 atorium imposed under subparagraph (A).

10 "(7) COMPLIANCE PROGRAMS.—

11 "(A) IN GENERAL.—On or after the date
12 of implementation determined by the Secretary
13 under subparagraph (C), a provider of medical
14 or other items or services or supplier within a
15 particular industry sector or category shall, as
16 a condition of enrollment in the program under
17 this title, title XIX, or title XXI, establish a
18 compliance program that contains the core ele-
19 ments established under subparagraph (B) with
20 respect to that provider or supplier and indus-
21 try or category.

22 "(B) ESTABLISHMENT OF CORE ELE-
23 MENTS.—The Secretary, in consultation with
24 the Inspector General of the Department of
25 Health and Human Services, shall establish

core elements for a compliance program under subparagraph (A) for providers or suppliers within a particular industry or category.

"(C) TIMELINE FOR IMPLEMENTATION.—The Secretary shall determine the timeline for the establishment of the core elements under subparagraph (B) and the date of the implementation of subparagraph (A) for providers or suppliers within a particular industry or category. The Secretary shall, in determining such date of implementation, consider the extent to which the adoption of compliance programs by a provider of medical or other items or services or supplier is widespread in a particular industry sector or with respect to a particular provider or supplier category.".

(b) MEDICAID.—

(1) STATE PLAN AMENDMENT.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by section 4302(b), is amended—

(A) in subsection (a)—

(i) by striking "and" at the end of paragraph (75);

(ii) by striking the period at the end of paragraph (76) and inserting a semicolon; and

(iii) by inserting after paragraph (76) the following:

"(77) provide that the State shall comply with provider and supplier screening, oversight, and reporting requirements in accordance with subsection (ii);"; and

(B) by adding at the end the following:

"(ii) PROVIDER AND SUPPLIER SCREENING, OVERSIGHT, AND REPORTING REQUIREMENTS.—For purposes of subsection (a)(77), the requirements of this subsection are the following:

"(1) SCREENING.—The State complies with the process for screening providers and suppliers under this title, as established by the Secretary under section 1886(j)(2).

"(2) PROVISIONAL PERIOD OF ENHANCED OVERSIGHT FOR NEW PROVIDERS AND SUPPLIERS.—The State complies with procedures to provide for a provisional period of enhanced oversight for new providers and suppliers under this title, as established by the Secretary under section 1886(j)(3).

"(3) DISCLOSURE REQUIREMENTS.—The State requires providers and suppliers under the State plan or under a waiver of the plan to comply with the disclosure requirements established by the Secretary under section 1886(j)(4).

"(4) TEMPORARY MORATORIUM ON ENROLLMENT OF NEW PROVIDERS OR SUPPLIERS.—

"(A) TEMPORARY MORATORIUM IMPOSED BY THE SECRETARY.—

"(i) IN GENERAL.—Subject to clause (ii), the State complies with any temporary moratorium on the enrollment of new providers or suppliers imposed by the Secretary under section 1886(j)(6).

"(ii) EXCEPTION.—A State shall not be required to comply with a temporary moratorium described in clause (i) if the State determines that the imposition of such temporary moratorium would adversely impact beneficiaries' access to medical assistance.

"(B) MORATORIUM ON ENROLLMENT OF PROVIDERS AND SUPPLIERS.—At the option of the State, the State imposes, for purposes of entering into participation agreements with pro-

viders or suppliers under the State plan or under a waiver of the plan, periods of enrollment moratoria, or numerical caps or other limits, for providers or suppliers identified by the Secretary as being at high-risk for fraud, waste, or abuse as necessary to combat fraud, waste, or abuse, but only if the State determines that the imposition of any such period, cap, or other limits would not adversely impact beneficiaries' access to medical assistance.

"(5) COMPLIANCE PROGRAMS.—The State requires providers and suppliers under the State plan or under a waiver of the plan to establish, in accordance with the requirements of section 1866(j)(7), a compliance program that contains the core elements established under subparagraph (B) of that section 1866(j)(7) for providers or suppliers within a particular industry or category.

"(6) REPORTING OF ADVERSE PROVIDER ACTIONS.—The State complies with the national system for reporting criminal and civil convictions, sanctions, negative licensure actions, and other adverse provider actions to the Secretary, through the Administrator of the Centers for Medicare & Med-

1 icaid Services, in accordance with regulations of the
2 Secretary.
3 ''(7) ENROLLMENT AND NPI OF ORDERING OR
4 REFERRING PROVIDERS.—The State requires—
5 ''(A) all ordering or referring physicians or
6 other professionals to be enrolled under the
7 State plan or under a waiver of the plan as a
8 participating provider; and
9 ''(B) the national provider identifier of any
10 ordering or referring physician or other profes-
11 sional to be specified on any claim for payment
12 that is based on an order or referral of the phy-
13 sician or other professional.
14 ''(8) OTHER STATE OVERSIGHT.—Nothing in
15 this subsection shall be interpreted to preclude or
16 limit the ability of a State to engage in provider and
17 supplier screening or enhanced provider and supplier
18 oversight activities beyond those required by the Sec-
19 retary.''.
20 (2) DISCLOSURE OF MEDICARE TERMINATED
21 PROVIDERS AND SUPPLIERS TO STATES.—The Ad-
22 ministrator of the Centers for Medicare & Medicaid
23 Services shall establish a process for making avail-
24 able to the each State agency with responsibility for
25 administering a State Medicaid plan (or a waiver of

1 such plan) under title XIX of the Social Security
2 Act or a child health plan under title XXI the name,
3 national provider identifier, and other identifying in-
4 formation for any provider of medical or other items
5 or services or supplier under the Medicare program
6 under title XVIII or under the CHIP program under
7 title XXI that is terminated from participation
8 under that program within 30 days of the termi-
9 nation (and, with respect to all such providers or
10 suppliers who are terminated from the Medicare pro-
11 gram on the date of enactment of this Act, within
12 90 days of such date).

13 (3) CONFORMING AMENDMENT.—Section
14 1902(a)(23) of the Social Security Act (42 U.S.C.
15 1396a), is amended by inserting before the semi-
16 colon at the end the following: ''or by a provider or
17 supplier to which a moratorium under subsection
18 (ii)(4) is applied during the period of such morato-
19 rium''.

20 (c) CHIP.—Section 2107(e)(1) of the Social Security
21 Act (42 U.S.C. 1397gg(e)(1)), as amended by section
22 2101(d), is amended—

23 (1) by redesignating subparagraphs (D)
24 through (M) as subparagraphs (E) through (N), re-
25 spectively; and

(2) by inserting after subparagraph (C), the following:

"(D) Subsections (a)(77) and (ii) of section 1902 (relating to provider and supplier screening, oversight, and reporting requirements).".

SEC. 6402. ENHANCED MEDICARE AND MEDICAID PROGRAM INTEGRITY PROVISIONS.

(a) IN GENERAL.—Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.), as amended by sections 6002, 6004, and 6102, is amended by inserting after section 1128I the following new section:

"SEC. 1128J. MEDICARE AND MEDICAID PROGRAM INTEGRITY PROVISIONS.

"(a) DATA MATCHING.—

"(1) INTEGRATED DATA REPOSITORY.—

"(A) INCLUSION OF CERTAIN DATA.—

"(i) IN GENERAL.—The Integrated Data Repository of the Centers for Medicare & Medicaid Services shall include, at a minimum, claims and payment data from the following:

"(I) The programs under titles XVIII and XIX (including parts A, B, C, and D of title XVIII).

"(II) The program under title XXI.

"(III) Health-related programs administered by the Secretary of Veterans Affairs.

"(IV) Health-related programs administered by the Secretary of Defense.

"(V) The program of old-age, survivors, and disability insurance benefits established under title II.

"(VI) The Indian Health Service and the Contract Health Service program.

"(ii) PRIORITY FOR INCLUSION OF CERTAIN DATA.—Inclusion of the data described in subclause (I) of such clause in the Integrated Data Repository shall be a priority. Data described in subclauses (II) through (VI) of such clause shall be included in the Integrated Data Repository as appropriate.

"(B) DATA SHARING AND MATCHING.—

"(i) IN GENERAL.—The Secretary shall enter into agreements with the indi-

viduals described in clause (ii) under which such individuals share and match data in the system of records of the respective agencies of such individuals with data in the system of records of the Department of Health and Human Services for the purpose of identifying potential fraud, waste, and abuse under the programs under titles XVIII and XIX.

"(ii) INDIVIDUALS DESCRIBED.—The following individuals are described in this clause:

"(I) The Commissioner of Social Security.

"(II) The Secretary of Veterans Affairs.

"(III) The Secretary of Defense.

"(IV) The Director of the Indian Health Service.

"(iii) DEFINITION OF SYSTEM OF RECORDS.—For purposes of this paragraph, the term 'system of records' has the meaning given such term in section 552a(a)(5) of title 5, United States Code.

1 "(2) ACCESS TO CLAIMS AND PAYMENT DATA-
2 BASES.—For purposes of conducting law enforce-
3 ment and oversight activities and to the extent con-
4 sistent with applicable information, privacy, security,
5 and disclosure laws, including the regulations pro-
6 mulgated under the Health Insurance Portability
7 and Accountability Act of 1996 and section 552a of
8 title 5, United States Code, and subject to any infor-
9 mation systems security requirements under such
10 laws or otherwise required by the Secretary, the In-
11 spector General of the Department of Health and
12 Human Services and the Attorney General shall
13 have access to claims and payment data of the De-
14 partment of Health and Human Services and its
15 contractors related to titles XVIII, XIX, and XXI.
16 "(b) OIG AUTHORITY TO OBTAIN INFORMATION.—
17 "(1) IN GENERAL.—Notwithstanding and in ad-
18 dition to any other provision of law, the Inspector
19 General of the Department of Health and Human
20 Services may, for purposes of protecting the integ-
21 rity of the programs under titles XVIII and XIX,
22 obtain information from any individual (including a
23 beneficiary provided all applicable privacy protec-
24 tions are followed) or entity that—

"(A) is a provider of medical or other items or services, supplier, grant recipient, contractor, or subcontractor; or

"(B) directly or indirectly provides, orders, manufactures, distributes, arranges for, prescribes, supplies, or receives medical or other items or services payable by any Federal health care program (as defined in section 1128B(f)) regardless of how the item or service is paid for, or to whom such payment is made.

"(2) INCLUSION OF CERTAIN INFORMATION.—Information which the Inspector General may obtain under paragraph (1) includes any supporting documentation necessary to validate claims for payment or payments under title XVIII or XIX, including a prescribing physician's medical records for an individual who is prescribed an item or service which is covered under part B of title XVIII, a covered part D drug (as defined in section 1860D–2(e)) for which payment is made under an MA–PD plan under part C of such title, or a prescription drug plan under part D of such title, and any records necessary for evaluation of the economy, efficiency, and effectiveness of the programs under titles XVIII and XIX.

1 "(c) ADMINISTRATIVE REMEDY FOR KNOWING PAR-
2 TICIPATION BY BENEFICIARY IN HEALTH CARE FRAUD
3 SCHEME.—
4 "(1) IN GENERAL.—In addition to any other
5 applicable remedies, if an applicable individual has
6 knowingly participated in a Federal health care
7 fraud offense or a conspiracy to commit a Federal
8 health care fraud offense, the Secretary shall impose
9 an appropriate administrative penalty commensurate
10 with the offense or conspiracy.
11 "(2) APPLICABLE INDIVIDUAL.—For purposes
12 of paragraph (1), the term 'applicable individual'
13 means an individual—
14 "(A) entitled to, or enrolled for, benefits
15 under part A of title XVIII or enrolled under
16 part B of such title;
17 "(B) eligible for medical assistance under
18 a State plan under title XIX or under a waiver
19 of such plan; or
20 "(C) eligible for child health assistance
21 under a child health plan under title XXI.
22 "(d) REPORTING AND RETURNING OF OVERPAY-
23 MENTS.—
24 "(1) IN GENERAL.—If a person has received an
25 overpayment, the person shall—

"(A) report and return the overpayment to the Secretary, the State, an intermediary, a carrier, or a contractor, as appropriate, at the correct address; and

"(B) notify the Secretary, State, intermediary, carrier, or contractor to whom the overpayment was returned in writing of the reason for the overpayment.

"(2) DEADLINE FOR REPORTING AND RETURNING OVERPAYMENTS.—An overpayment must be reported and returned under paragraph (1) by the later of—

"(A) the date which is 60 days after the date on which the overpayment was identified; or

"(B) the date any corresponding cost report is due, if applicable.

"(3) ENFORCEMENT.—Any overpayment retained by a person after the deadline for reporting and returning the overpayment under paragraph (2) is an obligation (as defined in section 3729(b)(3) of title 31, United States Code) for purposes of section 3729 of such title.

"(4) DEFINITIONS.—In this subsection:

"(A) KNOWING AND KNOWINGLY.—The terms 'knowing' and 'knowingly' have the meaning given those terms in section 3729(b) of title 31, United States Code.

"(B) OVERPAYMENT.—The term "overpayment" means any funds that a person receives or retains under title XVIII or XIX to which the person, after applicable reconciliation, is not entitled under such title.

"(C) PERSON.—

"(i) IN GENERAL.—The term 'person' means a provider of services, supplier, medicaid managed care organization (as defined in section 1903(m)(1)(A)), Medicare Advantage organization (as defined in section 1859(a)(1)), or PDP sponsor (as defined in section 1860D–41(a)(13)).

"(ii) EXCLUSION.—Such term does not include a beneficiary.

"(e) INCLUSION OF NATIONAL PROVIDER IDENTIFIER ON ALL APPLICATIONS AND CLAIMS.—The Secretary shall promulgate a regulation that requires, not later than January 1, 2011, all providers of medical or other items or services and suppliers under the programs under titles XVIII and XIX that qualify for a national

provider identifier to include their national provider identifier on all applications to enroll in such programs and on all claims for payment submitted under such programs.''.

(b) ACCESS TO DATA.—

(1) MEDICARE PART D.—Section 1860D–15(f)(2) of the Social Security Act (42 U.S.C. 1395w–116(f)(2)) is amended by striking ''may be used by'' and all that follows through the period at the end and inserting ''may be used—

''(A) by officers, employees, and contractors of the Department of Health and Human Services for the purposes of, and to the extent necessary in—

''(i) carrying out this section; and

''(ii) conducting oversight, evaluation, and enforcement under this title; and

''(B) by the Attorney General and the Comptroller General of the United States for the purposes of, and to the extent necessary in, carrying out health oversight activities.''.

(2) DATA MATCHING.—Section 552a(a)(8)(B) of title 5, United States Code, is amended—

(A) in clause (vii), by striking ''or'' at the end;

(B) in clause (viii), by inserting ''or'' after the semicolon; and

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

''(ix) matches performed by the Secretary of Health and Human Services or the Inspector General of the Department of Health and Human Services with respect to potential fraud, waste, and abuse, including matches of a system of records with non-Federal records;''.

(3) MATCHING AGREEMENTS WITH THE COMMISSIONER OF SOCIAL SECURITY.—Section 205(r) of the Social Security Act (42 U.S.C. 405(r)) is amended by adding at the end the following new paragraph:

''(9)(A) The Commissioner of Social Security shall, upon the request of the Secretary or the Inspector General of the Department of Health and Human Services—

''(i) enter into an agreement with the Secretary or such Inspector General for the purpose of matching data in the system of records of the Social Security Administration and the

system of records of the Department of Health and Human Services; and

"(ii) include in such agreement safeguards to assure the maintenance of the confidentiality of any information disclosed.

"(B) For purposes of this paragraph, the term 'system of records' has the meaning given such term in section 552a(a)(5) of title 5, United States Code.".

(c) WITHHOLDING OF FEDERAL MATCHING PAYMENTS FOR STATES THAT FAIL TO REPORT ENROLLEE ENCOUNTER DATA IN THE MEDICAID STATISTICAL INFORMATION SYSTEM.—Section 1903(i) of the Social Security Act (42 U.S.C. 1396b(i)) is amended—

(1) in paragraph (23), by striking "or" at the end;

(2) in paragraph (24), by striking the period at the end and inserting "; or"; and

(3) by adding at the end the following new paragraph:.

"(25) with respect to any amounts expended for medical assistance for individuals for whom the State does not report enrollee encounter data (as defined by the Secretary) to the Medicaid Statistical

1 Information System (MSIS) in a timely manner (as
2 determined by the Secretary).''.
3 (d) PERMISSIVE EXCLUSIONS AND CIVIL MONETARY
4 PENALTIES.—
5 (1) PERMISSIVE EXCLUSIONS.—Section 1128(b)
6 of the Social Security Act (42 U.S.C. 1320a–7(b))
7 is amended by adding at the end the following new
8 paragraph:
9 ''(16) MAKING FALSE STATEMENTS OR MIS-
10 REPRESENTATION OF MATERIAL FACTS.—Any indi-
11 vidual or entity that knowingly makes or causes to
12 be made any false statement, omission, or misrepre-
13 sentation of a material fact in any application,
14 agreement, bid, or contract to participate or enroll
15 as a provider of services or supplier under a Federal
16 health care program (as defined in section
17 1128B(f)), including Medicare Advantage organiza-
18 tions under part C of title XVIII, prescription drug
19 plan sponsors under part D of title XVIII, medicaid
20 managed care organizations under title XIX, and en-
21 tities that apply to participate as providers of serv-
22 ices or suppliers in such managed care organizations
23 and such plans.''.
24 (2) CIVIL MONETARY PENALTIES.—

(A) IN GENERAL.—Section 1128A(a) of the Social Security Act (42 U.S.C. 1320a–7a(a)) is amended—

(i) in paragraph (1)(D), by striking ''was excluded'' and all that follows through the period at the end and inserting ''was excluded from the Federal health care program (as defined in section 1128B(f)) under which the claim was made pursuant to Federal law.'';

(ii) in paragraph (6), by striking ''or'' at the end;

(iii) by inserting after paragraph (7), the following new paragraphs:

''(8) orders or prescribes a medical or other item or service during a period in which the person was excluded from a Federal health care program (as so defined), in the case where the person knows or should know that a claim for such medical or other item or service will be made under such a program;

''(9) knowingly makes or causes to be made any false statement, omission, or misrepresentation of a material fact in any application, bid, or contract to participate or enroll as a provider of services or a

supplier under a Federal health care program (as so defined), including Medicare Advantage organizations under part C of title XVIII, prescription drug plan sponsors under part D of title XVIII, medicaid managed care organizations under title XIX, and entities that apply to participate as providers of services or suppliers in such managed care organizations and such plans;

''(10) knows of an overpayment (as defined in paragraph (4) of section 1128J(d)) and does not report and return the overpayment in accordance with such section;'';

(iv) in the first sentence—

(I) by striking the ''or'' after ''prohibited relationship occurs;''; and

(II) by striking ''act)'' and inserting ''act; or in cases under paragraph (9), $50,000 for each false statement or misrepresentation of a material fact)''; and

(v) in the second sentence, by striking ''purpose)'' and inserting ''purpose; or in cases under paragraph (9), an assessment of not more than 3 times the total amount claimed for each item or service for which

payment was made based upon the application containing the false statement or misrepresentation of a material fact)''.

(B) CLARIFICATION OF TREATMENT OF CERTAIN CHARITABLE AND OTHER INNOCUOUS PROGRAMS.—Section 1128A(i)(6) of the Social Security Act (42 U.S.C. 1320a–7a(i)(6)) is amended—

(i) in subparagraph (C), by striking ''or'' at the end;

(ii) in subparagraph (D), as redesignated by section 4331(e) of the Balanced Budget Act of 1997 (Public Law 105–33), by striking the period at the end and inserting a semicolon;

(iii) by redesignating subparagraph (D), as added by section 4523(c) of such Act, as subparagraph (E) and striking the period at the end and inserting ''; or''; and

(iv) by adding at the end the following new subparagraphs:

''(F) any other remuneration which promotes access to care and poses a low risk of harm to patients and Federal health care pro-

1 grams (as defined in section 1128B(f) and des-
2 ignated by the Secretary under regulations);
3 "(G) the offer or transfer of items or serv-
4 ices for free or less than fair market value by
5 a person, if—
6 "(i) the items or services consist of
7 coupons, rebates, or other rewards from a
8 retailer;
9 "(ii) the items or services are offered
10 or transferred on equal terms available to
11 the general public, regardless of health in-
12 surance status; and
13 "(iii) the offer or transfer of the items
14 or services is not tied to the provision of
15 other items or services reimbursed in whole
16 or in part by the program under title
17 XVIII or a State health care program (as
18 defined in section 1128(h));
19 "(H) the offer or transfer of items or serv-
20 ices for free or less than fair market value by
21 a person, if—
22 "(i) the items or services are not of-
23 fered as part of any advertisement or solic-
24 itation;

"(ii) the items or services are not tied to the provision of other services reimbursed in whole or in part by the program under title XVIII or a State health care program (as so defined);

"(iii) there is a reasonable connection between the items or services and the medical care of the individual; and

"(iv) the person provides the items or services after determining in good faith that the individual is in financial need; or

"(I) effective on a date specified by the Secretary (but not earlier than January 1, 2011), the waiver by a PDP sponsor of a prescription drug plan under part D of title XVIII or an MA organization offering an MA–PD plan under part C of such title of any copayment for the first fill of a covered part D drug (as defined in section 1860D–2(e)) that is a generic drug for individuals enrolled in the prescription drug plan or MA–PD plan, respectively.".

(e) TESTIMONIAL SUBPOENA AUTHORITY IN EXCLUSION-ONLY CASES.—Section 1128(f) of the Social Secu-

rity Act (42 U.S.C. 1320a–7(f)) is amended by adding at the end the following new paragraph:

"(4) The provisions of subsections (d) and (e) of section 205 shall apply with respect to this section to the same extent as they are applicable with respect to title II. The Secretary may delegate the authority granted by section 205(d) (as made applicable to this section) to the Inspector General of the Department of Health and Human Services for purposes of any investigation under this section.".

(f) HEALTH CARE FRAUD.—

(1) KICKBACKS.—Section 1128B of the Social Security Act (42 U.S.C. 1320a–7b) is amended by adding at the end the following new subsection:

"(g) In addition to the penalties provided for in this section or section 1128A, a claim that includes items or services resulting from a violation of this section constitutes a false or fraudulent claim for purposes of subchapter III of chapter 37 of title 31, United States Code.".

(2) REVISING THE INTENT REQUIREMENT.—Section 1128B of the Social Security Act (42 U.S.C. 1320a–7b), as amended by paragraph (1), is amended by adding at the end the following new subsection:

1 "(h) With respect to violations of this section, a per-
2 son need not have actual knowledge of this section or spe-
3 cific intent to commit a violation of this section.".

4 (g) SURETY BOND REQUIREMENTS.—

5 (1) DURABLE MEDICAL EQUIPMENT.—Section
6 1834(a)(16)(B) of the Social Security Act (42
7 U.S.C. 1395m(a)(16)(B)) is amended by inserting
8 "that the Secretary determines is commensurate
9 with the volume of the billing of the supplier" before
10 the period at the end.

11 (2) HOME HEALTH AGENCIES.—Section
12 1861(o)(7)(C) of the Social Security Act (42 U.S.C.
13 1395x(o)(7)(C)) is amended by inserting "that the
14 Secretary determines is commensurate with the vol-
15 ume of the billing of the home health agency" before
16 the semicolon at the end.

17 (3) REQUIREMENTS FOR CERTAIN OTHER PRO-
18 VIDERS OF SERVICES AND SUPPLIERS.—Section
19 1862 of the Social Security Act (42 U.S.C. 1395y)
20 is amended by adding at the end the following new
21 subsection:

22 "(n) REQUIREMENT OF A SURETY BOND FOR CER-
23 TAIN PROVIDERS OF SERVICES AND SUPPLIERS.—

24 "(1) IN GENERAL.—The Secretary may require
25 a provider of services or supplier described in para-

graph (2) to provide the Secretary on a continuing basis with a surety bond in a form specified by the Secretary in an amount (not less than $50,000) that the Secretary determines is commensurate with the volume of the billing of the provider of services or supplier. The Secretary may waive the requirement of a bond under the preceding sentence in the case of a provider of services or supplier that provides a comparable surety bond under State law.

"(2) PROVIDER OF SERVICES OR SUPPLIER DESCRIBED.—A provider of services or supplier described in this paragraph is a provider of services or supplier the Secretary determines appropriate based on the level of risk involved with respect to the provider of services or supplier, and consistent with the surety bond requirements under sections 1834(a)(16)(B) and 1861(o)(7)(C).".

(h) SUSPENSION OF MEDICARE AND MEDICAID PAYMENTS PENDING INVESTIGATION OF CREDIBLE ALLEGATIONS OF FRAUD.—

(1) MEDICARE.—Section 1862 of the Social Security Act (42 U.S.C. 1395y), as amended by subsection (g)(3), is amended by adding at the end the following new subsection:

1 "(o) SUSPENSION OF PAYMENTS PENDING INVES-
2 TIGATION OF CREDIBLE ALLEGATIONS OF FRAUD.—
3 "(1) IN GENERAL.—The Secretary may suspend
4 payments to a provider of services or supplier under
5 this title pending an investigation of a credible alle-
6 gation of fraud against the provider of services or
7 supplier, unless the Secretary determines there is
8 good cause not to suspend such payments.
9 "(2) CONSULTATION.—The Secretary shall con-
10 sult with the Inspector General of the Department
11 of Health and Human Services in determining
12 whether there is a credible allegation of fraud
13 against a provider of services or supplier.
14 "(3) PROMULGATION OF REGULATIONS.—The
15 Secretary shall promulgate regulations to carry out
16 this subsection and section 1903(i)(2)(C).".
17 (2) MEDICAID.—Section 1903(i)(2) of such Act
18 (42 U.S.C. 1396b(i)(2)) is amended—
19 (A) in subparagraph (A), by striking "or"
20 at the end; and
21 (B) by inserting after subparagraph (B),
22 the following:
23 "(C) by any individual or entity to whom
24 the State has failed to suspend payments under
25 the plan during any period when there is pend-

ing an investigation of a credible allegation of fraud against the individual or entity, as determined by the State in accordance with regulations promulgated by the Secretary for purposes of section 1862(o) and this subparagraph, unless the State determines in accordance with such regulations there is good cause not to suspend such payments; or''.

(i) INCREASED FUNDING TO FIGHT FRAUD AND ABUSE.—

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

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

''(7) ADDITIONAL FUNDING.—In addition to the funds otherwise appropriated to the Account from the Trust Fund under paragraphs (3) and (4) and for purposes described in paragraphs (3)(C) and (4)(A), there are hereby appropriated an additional $10,000,000 to such Account from such Trust Fund for each of fiscal years 2011 through 2020. The funds appropriated under this paragraph shall be allocated in the same proportion as the total funding appropriated with respect to paragraphs (3)(A) and (4)(A) was allocated with respect to fiscal year

2010, and shall be available without further appropriation until expended.''; and

(B) in paragraph (4)(A), by inserting ''until expended'' after ''appropriation''.

(2) INDEXING OF AMOUNTS APPROPRIATED.—

(A) DEPARTMENTS OF HEALTH AND HUMAN SERVICES AND JUSTICE.—Section 1817(k)(3)(A)(i) of the Social Security Act (42 U.S.C. 1395i(k)(3)(A)(i)) is amended—

(i) in subclause (III), by inserting ''and'' at the end;

(ii) in subclause (IV)—

(I) by striking ''for each of fiscal years 2007, 2008, 2009, and 2010'' and inserting ''for each fiscal year after fiscal year 2006''; and

(II) by striking ''; and'' and inserting a period; and

(iii) by striking subclause (V).

(B) 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—

(i) in subclause (VIII), by inserting "and" at the end;

(ii) in subclause (IX)—

(I) by striking "for each of fiscal years 2008, 2009, and 2010" and inserting "for each fiscal year after fiscal year 2007"; and

(II) by striking "; and" and inserting a period; and

(iii) by striking subclause (X).

(C) FEDERAL BUREAU OF INVESTIGATION.—Section 1817(k)(3)(B) of the Social Security Act (42 U.S.C. 1395i(k)(3)(B)) is amended—

(i) in clause (vii), by inserting "and" at the end;

(ii) in clause (viii)—

(I) by striking "for each of fiscal years 2007, 2008, 2009, and 2010" and inserting "for each fiscal year after fiscal year 2006"; and

(II) by striking "; and" and inserting a period; and

(iii) by striking clause (ix).

(D) MEDICARE INTEGRITY PROGRAM.—Section 1817(k)(4)(C) of the Social Security Act (42 U.S.C. 1395i(k)(4)(C)) is amended by adding at the end the following new clause:

"(ii) For each fiscal year after 2010, by the percentage increase in the consumer price index for all urban consumers (all items; United States city average) over the previous year.".

(j) MEDICARE INTEGRITY PROGRAM AND MEDICAID INTEGRITY PROGRAM.—

(1) MEDICARE INTEGRITY PROGRAM.—

(A) REQUIREMENT TO PROVIDE PERFORMANCE STATISTICS.—Section 1893(c) of the Social Security Act (42 U.S.C. 1395ddd(c)) is amended—

(i) in paragraph (3), by striking "and" at the end;

(ii) by redesignating paragraph (4) as paragraph (5); and

(iii) by inserting after paragraph (3) the following new paragraph:

"(4) the entity agrees to provide the Secretary and the Inspector General of the Department of Health and Human Services with such performance

statistics (including the number and amount of overpayments recovered, the number of fraud referrals, and the return on investment of such activities by the entity) as the Secretary or the Inspector General may request; and''.

(B) EVALUATIONS AND ANNUAL REPORT.—Section 1893 of the Social Security Act (42 U.S.C. 1395ddd) is amended by adding at the end the following new subsection:

''(i) EVALUATIONS AND ANNUAL REPORT.—

''(1) EVALUATIONS.—The Secretary shall conduct evaluations of eligible entities which the Secretary contracts with under the Program not less frequently than every 3 years.

''(2) ANNUAL REPORT.—Not later than 180 days after the end of each fiscal year (beginning with fiscal year 2011), the Secretary shall submit a report to Congress which identifies—

''(A) the use of funds, including funds transferred from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Insurance Trust Fund under section 1841, to carry out this section; and

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

(C) FLEXIBILITY IN PURSUING FRAUD AND ABUSE.—Section 1893(a) of the Social Security Act (42 U.S.C. 1395ddd(a)) is amended by inserting ", or otherwise," after "entities".

(2) MEDICAID INTEGRITY PROGRAM.—

(A) REQUIREMENT TO PROVIDE PERFORMANCE STATISTICS.—Section 1936(c)(2) of the Social Security Act (42 U.S.C. 1396u–6(c)(2)) is amended—

(i) by redesignating subparagraph (D) as subparagraph (E); and

(ii) by inserting after subparagraph (C) the following new subparagraph:

"(D) The entity agrees to provide the Secretary and the Inspector General of the Department of Health and Human Services with such performance statistics (including the number and amount of overpayments recovered, the number of fraud referrals, and the return on investment of such activities by the entity) as the Secretary or the Inspector General may request.".

(B) EVALUATIONS AND ANNUAL REPORT.—Section 1936(e) of the Social Security Act (42 U.S.C. 1396u–7(e)) is amended—

(i) by redesignating paragraph (4) as paragraph (5); and

(ii) by inserting after paragraph (3) the following new paragraph:

''(4) EVALUATIONS.—The Secretary shall conduct evaluations of eligible entities which the Secretary contracts with under the Program not less frequently than every 3 years.''.

(k) EXPANDED APPLICATION OF HARDSHIP WAIVERS FOR EXCLUSIONS.—Section 1128(c)(3)(B) of the Social Security Act (42 U.S.C. 1320a–7(c)(3)(B)) is amended by striking ''individuals entitled to benefits under part A of title XVIII or enrolled under part B of such title, or both'' and inserting ''beneficiaries (as defined in section 1128A(i)(5)) of that program''.

SEC. 6403. ELIMINATION OF DUPLICATION BETWEEN THE HEALTHCARE INTEGRITY AND PROTECTION DATA BANK AND THE NATIONAL PRACTITIONER DATA BANK.

(a) INFORMATION REPORTED BY FEDERAL AGENCIES AND HEALTH PLANS.—Section 1128E of the Social Security Act (42 U.S.C. 1320a–7e) is amended—

(1) by striking subsection (a) and inserting the following:

"(a) IN GENERAL.—The Secretary shall maintain a national health care fraud and abuse data collection program under this section for the reporting of certain final adverse actions (not including settlements in which no findings of liability have been made) against health care providers, suppliers, or practitioners as required by subsection (b), with access as set forth in subsection (d), and shall furnish the information collected under this section to the National Practitioner Data Bank established pursuant to the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11101 et seq.).";

(2) by striking subsection (d) and inserting the following:

"(d) ACCESS TO REPORTED INFORMATION.—

"(1) AVAILABILITY.—The information collected under this section shall be available from the National Practitioner Data Bank to the agencies, authorities, and officials which are provided under section 1921(b) information reported under section 1921(a).

"(2) FEES FOR DISCLOSURE.—The Secretary may establish or approve reasonable fees for the disclosure of information under this section. The

amount of such a fee may not exceed the costs of processing the requests for disclosure and of providing such information. Such fees shall be available to the Secretary to cover such costs.'';

(3) by striking subsection (f) and inserting the following:

''(f) APPROPRIATE COORDINATION.—In implementing this section, the Secretary shall provide for the maximum appropriate coordination with part B of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11131 et seq.) and section 1921.''; and

(4) in subsection (g)—

(A) in paragraph (1)(A)—

(i) in clause (iii)—

(I) by striking ''or State'' each place it appears;

(II) by redesignating subclauses (II) and (III) as subclauses (III) and (IV), respectively; and

(III) by inserting after subclause (I) the following new subclause:

''(II) any dismissal or closure of the proceedings by reason of the provider, supplier, or practitioner surren-

dering their license or leaving the State or jurisdiction''; and

(ii) by striking clause (iv) and inserting the following:

''(iv) Exclusion from participation in a Federal health care program (as defined in section 1128B(f)).'';

(B) in paragraph (3)—

(i) by striking subparagraphs (D) and (E); and

(ii) by redesignating subparagraph (F) as subparagraph (D); and

(C) in subparagraph (D) (as so redesignated), by striking ''or State''.

(b) INFORMATION REPORTED BY STATE LAW OR FRAUD ENFORCEMENT AGENCIES.—Section 1921 of the Social Security Act (42 U.S.C. 1396r–2) is amended—

(1) in subsection (a)—

(A) in paragraph (1)—

(i) by striking ''SYSTEM.—The State'' and all that follows through the semicolon and inserting SYSTEM.—

''(A) LICENSING OR CERTIFICATION ACTIONS.—The State must have in effect a system of reporting the following information with re-

spect to formal proceedings (as defined by the Secretary in regulations) concluded against a health care practitioner or entity by a State licensing or certification agency:'';

(ii) by redesignating subparagraphs (A) through (D) as clauses (i) through (iv), respectively, and indenting appropriately;

(iii) in subparagraph (A)(iii) (as so redesignated)—

(I) by striking ''the license of'' and inserting ''license or the right to apply for, or renew, a license by''; and

(II) by inserting ''nonrenewability,'' after ''voluntary surrender,''; and

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

''(B) OTHER FINAL ADVERSE ACTIONS.—The State must have in effect a system of reporting information with respect to any final adverse action (not including settlements in which no findings of liability have been made) taken against a health care provider, supplier,

or practitioner by a State law or fraud enforcement agency.''; and

(B) in paragraph (2), by striking ''the authority described in paragraph (1)'' and inserting ''a State licensing or certification agency or State law or fraud enforcement agency'';

(2) in subsection (b)—

(A) by striking paragraph (2) and inserting the following:

''(2) to State licensing or certification agencies and Federal agencies responsible for the licensing and certification of health care providers, suppliers, and licensed health care practitioners;'';

(B) in each of paragraphs (4) and (6), by inserting '', but only with respect to information provided pursuant to subsection (a)(1)(A)'' before the comma at the end;

(C) by striking paragraph (5) and inserting the following:

''(5) to State law or fraud enforcement agencies,'';

(D) by redesignating paragraphs (7) and (8) as paragraphs (8) and (9), respectively; and

(E) by inserting after paragraph (6) the following new paragraph:

"(7) to health plans (as defined in section 1128C(c));";

(3) by redesignating subsection (d) as subsection (h), and by inserting after subsection (c) the following new subsections:

"(d) DISCLOSURE AND CORRECTION OF INFORMATION.—

"(1) DISCLOSURE.—With respect to information reported pursuant to subsection (a)(1), the Secretary shall—

"(A) provide for disclosure of the information, upon request, to the health care practitioner who, or the entity that, is the subject of the information reported; and

"(B) establish procedures for the case where the health care practitioner or entity disputes the accuracy of the information reported.

"(2) CORRECTIONS.—Each State licensing or certification agency and State law or fraud enforcement agency shall report corrections of information already reported about any formal proceeding or final adverse action described in subsection (a), in such form and manner as the Secretary prescribes by regulation.

1 "(e) FEES FOR DISCLOSURE.—The Secretary may
2 establish or approve reasonable fees for the disclosure of
3 information under this section. The amount of such a fee
4 may not exceed the costs of processing the requests for
5 disclosure and of providing such information. Such fees
6 shall be available to the Secretary to cover such costs.

7 "(f) PROTECTION FROM LIABILITY FOR REPORT-
8 ING.—No person or entity, including any agency des-
9 ignated by the Secretary in subsection (b), shall be held
10 liable in any civil action with respect to any reporting of
11 information as required under this section, without knowl-
12 edge of the falsity of the information contained in the re-
13 port.

14 "(g) REFERENCES.—For purposes of this section:

15 "(1) STATE LICENSING OR CERTIFICATION
16 AGENCY.—The term 'State licensing or certification
17 agency' includes any authority of a State (or of a
18 political subdivision thereof) responsible for the li-
19 censing of health care practitioners (or any peer re-
20 view organization or private accreditation entity re-
21 viewing the services provided by health care practi-
22 tioners) or entities.

23 "(2) STATE LAW OR FRAUD ENFORCEMENT
24 AGENCY.—The term 'State law or fraud enforcement
25 agency' includes—

"(A) a State law enforcement agency; and

"(B) a State medicaid fraud control unit (as defined in section 1903(q)).

"(3) FINAL ADVERSE ACTION.—

"(A) IN GENERAL.—Subject to subparagraph (B), the term 'final adverse action' includes—

"(i) civil judgments against a health care provider, supplier, or practitioner in State court related to the delivery of a health care item or service;

"(ii) State criminal convictions related to the delivery of a health care item or service;

"(iii) exclusion from participation in State health care programs (as defined in section 1128(h));

"(iv) any licensing or certification action described in subsection (a)(1)(A) taken against a supplier by a State licensing or certification agency; and

"(v) any other adjudicated actions or decisions that the Secretary shall establish by regulation.

"(B) EXCEPTION.—Such term does not include any action with respect to a malpractice claim."; and

(4) in subsection (h), as so redesignated, by striking "The Secretary" and all that follows through the period at the end and inserting "In implementing this section, the Secretary shall provide for the maximum appropriate coordination with part B of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11131 et seq.) and section 1128E.".

(c) CONFORMING AMENDMENT.—Section 1128C(a)(1) of the Social Security Act (42 U.S.C. 1320a–7c(a)(1)) is amended—

(1) in subparagraph (C), by adding "and" after the comma at the end;

(2) in subparagraph (D), by striking ", and" and inserting a period; and

(3) by striking subparagraph (E).

(d) TRANSITION PROCESS; EFFECTIVE DATE.—

(1) IN GENERAL.—Effective on the date of enactment of this Act, the Secretary of Health and Human Services (in this section referred to as the "Secretary") shall implement a transition process under which, by not later than the end of the transi-

1 tion period described in paragraph (5), the Secretary
2 shall cease operating the Healthcare Integrity and
3 Protection Data Bank established under section
4 1128E of the Social Security Act (as in effect before
5 the effective date specified in paragraph (6)) and
6 shall transfer all data collected in the Healthcare In-
7 tegrity and Protection Data Bank to the National
8 Practitioner Data Bank established pursuant to the
9 Health Care Quality Improvement Act of 1986 (42
10 U.S.C. 11101 et seq.). During such transition proc-
11 ess, the Secretary shall have in effect appropriate
12 procedures to ensure that data collection and access
13 to the Healthcare Integrity and Protection Data
14 Bank and the National Practitioner Data Bank are
15 not disrupted.

16 (2) REGULATIONS.—The Secretary shall pro-
17 mulgate regulations to carry out the amendments
18 made by subsections (a) and (b).

19 (3) FUNDING.—

20 (A) AVAILABILITY OF FEES.—Fees col-
21 lected pursuant to section 1128E(d)(2) of the
22 Social Security Act prior to the effective date
23 specified in paragraph (6) for the disclosure of
24 information in the Healthcare Integrity and
25 Protection Data Bank shall be available to the

1 Secretary, without fiscal year limitation, for
2 payment of costs related to the transition proc-
3 ess described in paragraph (1). Any such fees
4 remaining after the transition period is com-
5 plete shall be available to the Secretary, without
6 fiscal year limitation, for payment of the costs
7 of operating the National Practitioner Data
8 Bank.

9 (B) AVAILABILITY OF ADDITIONAL
10 FUNDS.—In addition to the fees described in
11 subparagraph (A), any funds available to the
12 Secretary or to the Inspector General of the
13 Department of Health and Human Services for
14 a purpose related to combating health care
15 fraud, waste, or abuse shall be available to the
16 extent necessary for operating the Healthcare
17 Integrity and Protection Data Bank during the
18 transition period, including systems testing and
19 other activities necessary to ensure that infor-
20 mation formerly reported to the Healthcare In-
21 tegrity and Protection Data Bank will be acces-
22 sible through the National Practitioner Data
23 Bank after the end of such transition period.

(4) SPECIAL PROVISION FOR ACCESS TO THE NATIONAL PRACTITIONER DATA BANK BY THE DEPARTMENT OF VETERANS AFFAIRS.—

(A) IN GENERAL.—Notwithstanding any other provision of law, during the 1-year period that begins on the effective date specified in paragraph (6), the information described in subparagraph (B) shall be available from the National Practitioner Data Bank to the Secretary of Veterans Affairs without charge.

(B) INFORMATION DESCRIBED.—For purposes of subparagraph (A), the information described in this subparagraph is the information that would, but for the amendments made by this section, have been available to the Secretary of Veterans Affairs from the Healthcare Integrity and Protection Data Bank.

(5) TRANSITION PERIOD DEFINED.—For purposes of this subsection, the term ''transition period'' means the period that begins on the date of enactment of this Act and ends on the later of—

(A) the date that is 1 year after such date of enactment; or

(B) the effective date of the regulations promulgated under paragraph (2).

(6) EFFECTIVE DATE.—The amendments made by subsections (a), (b), and (c) shall take effect on the first day after the final day of the transition period.

SEC. 6404. MAXIMUM PERIOD FOR SUBMISSION OF MEDICARE CLAIMS REDUCED TO NOT MORE THAN 12 MONTHS.

(a) REDUCING MAXIMUM PERIOD FOR SUBMISSION.—

(1) PART A.—Section 1814(a) of the Social Security Act (42 U.S.C. 1395f(a)(1)) is amended—

(A) in paragraph (1), by striking ''period of 3 calendar years'' and all that follows through the semicolon and inserting ''period ending 1 calendar year after the date of service;''; and

(B) by adding at the end the following new sentence: ''In applying paragraph (1), the Secretary may specify exceptions to the 1 calendar year period specified in such paragraph.''

(2) PART B.—

(A) Section 1842(b)(3) of such Act (42 U.S.C. 1395u(b)(3)(B)) is amended—

(i) in subparagraph (B), in the flush language following clause (ii), by striking

"close of the calendar year following the year in which such service is furnished (deeming any service furnished in the last 3 months of any calendar year to have been furnished in the succeeding calendar year)" and inserting "period ending 1 calendar year after the date of service"; and

(ii) by adding at the end the following new sentence: "In applying subparagraph (B), the Secretary may specify exceptions to the 1 calendar year period specified in such subparagraph."

(B) Section 1835(a) of such Act (42 U.S.C. 1395n(a)) is amended—

(i) in paragraph (1), by striking "period of 3 calendar years" and all that follows through the semicolon and inserting "period ending 1 calendar year after the date of service;"; and

(ii) by adding at the end the following new sentence: "In applying paragraph (1), the Secretary may specify exceptions to the 1 calendar year period specified in such paragraph."

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by subsection (a) shall apply to services furnished on or after January 1, 2010.

(2) SERVICES FURNISHED BEFORE 2010.—In the case of services furnished before January 1, 2010, a bill or request for payment under section 1814(a)(1), 1842(b)(3)(B), or 1835(a) shall be filed not later that December 31, 2010.

SEC. 6405. PHYSICIANS WHO ORDER ITEMS OR SERVICES REQUIRED TO BE MEDICARE ENROLLED PHYSICIANS OR ELIGIBLE PROFESSIONALS.

(a) DME.—Section 1834(a)(11)(B) of the Social Security Act (42 U.S.C. 1395m(a)(11)(B)) is amended by striking ''physician'' and inserting ''physician enrolled under section 1866(j) or an eligible professional under section 1848(k)(3)(B) that is enrolled under section 1866(j)''.

(b) HOME HEALTH SERVICES.—

(1) PART A.—Section 1814(a)(2) of such Act (42 U.S.C. 1395(a)(2)) is amended in the matter preceding subparagraph (A) by inserting ''in the case of services described in subparagraph (C), a physician enrolled under section 1866(j) or an eligible professional under section 1848(k)(3)(B),'' before ''or, in the case of services''.

(2) PART B.—Section 1835(a)(2) of such Act (42 U.S.C. 1395n(a)(2)) is amended in the matter preceding subparagraph (A) by inserting ", or in the case of services described in subparagraph (A), a physician enrolled under section 1866(j) or an eligible professional under section 1848(k)(3)(B)," after "a physician".

(c) APPLICATION TO OTHER ITEMS OR SERVICES.—The Secretary may extend the requirement applied by the amendments made by subsections (a) and (b) to durable medical equipment and home health services (relating to requiring certifications and written orders to be made by enrolled physicians and health professions) to all other categories of items or services under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), including covered part D drugs as defined in section 1860D–2(e) of such Act (42 U.S.C. 1395w–102), that are ordered, prescribed, or referred by a physician enrolled under section 1866(j) of such Act (42 U.S.C. 1395cc(j)) or an eligible professional under section 1848(k)(3)(B) of such Act (42 U.S.C. 1395w–4(k)(3)(B)).

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to written orders and certifications made on or after July 1, 2010.

SEC. 6406. REQUIREMENT FOR PHYSICIANS TO PROVIDE DOCUMENTATION ON REFERRALS TO PROGRAMS AT HIGH RISK OF WASTE AND ABUSE.

(a) PHYSICIANS AND OTHER SUPPLIERS.—Section 1842(h) of the Social Security Act (42 U.S.C. 1395u(h)) is amended by adding at the end the following new paragraph

''(9) The Secretary may revoke enrollment, for a period of not more than one year for each act, for a physician or supplier under section 1866(j) if such physician or supplier fails to maintain and, upon request of the Secretary, provide access to documentation relating to written orders or requests for payment for durable medical equipment, certifications for home health services, or referrals for other items or services written or ordered by such physician or supplier under this title, as specified by the Secretary.''.

(b) PROVIDERS OF SERVICES.—Section 1866(a)(1) of such Act (42 U.S.C. 1395cc) is further amended—

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

(2) in subparagraph (V), by striking the period at the end and adding ''; and''; and

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

"(W) maintain and, upon request of the Secretary, provide access to documentation relating to written orders or requests for payment for durable medical equipment, certifications for home health services, or referrals for other items or services written or ordered by the provider under this title, as specified by the Secretary.".

(c) OIG PERMISSIVE EXCLUSION AUTHORITY.—Section 1128(b)(11) of the Social Security Act (42 U.S.C. 1320a–7(b)(11)) is amended by inserting ", ordering, referring for furnishing, or certifying the need for" after "furnishing".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to orders, certifications, and referrals made on or after January 1, 2010.

SEC. 6407. FACE TO FACE ENCOUNTER WITH PATIENT REQUIRED BEFORE PHYSICIANS MAY CERTIFY ELIGIBILITY FOR HOME HEALTH SERVICES OR DURABLE MEDICAL EQUIPMENT UNDER MEDICARE.

(a) CONDITION OF PAYMENT FOR HOME HEALTH SERVICES.—

(1) PART A.—Section 1814(a)(2)(C) of such Act is amended—

(A) by striking ''and such services'' and inserting ''such services''; and

(B) by inserting after ''care of a physician'' the following: '', and, in the case of a certification made by a physician after January 1, 2010, prior to making such certification the physician must document that the physician himself or herself has had a face-to-face encounter (including through use of telehealth, subject to the requirements in section 1834(m), and other than with respect to encounters that are incident to services involved) with the individual within a reasonable timeframe as determined by the Secretary''.

(2) PART B.—Section 1835(a)(2)(A) of the Social Security Act is amended—

(A) by striking ''and'' before ''(iii)''; and

(B) by inserting after ''care of a physician'' the following: '', and (iv) in the case of a certification after January 1, 2010, prior to making such certification the physician must document that the physician has had a face-to-face encounter (including through use of telehealth and other than with respect to encounters that are incident to services involved) with

the individual during the 6-month period preceding such certification, or other reasonable timeframe as determined by the Secretary''.

(b) CONDITION OF PAYMENT FOR DURABLE MEDICAL EQUIPMENT.—Section 1834(a)(11)(B) of the Social Security Act (42 U.S.C. 1395m(a)(11)(B)) is amended—

(1) by striking ''ORDER.—The Secretary'' and inserting ''ORDER.—

''(i) IN GENERAL.—The Secretary''; and

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

''(ii) REQUIREMENT FOR FACE TO FACE ENCOUNTER.—The Secretary shall require that such an order be written pursuant to the physician documenting that a physician, a physician assistant, a nurse practitioner, or a clinical nurse specialist (as those terms are defined in section 1861(aa)(5)) has had a face-to-face encounter (including through use of telehealth under subsection (m) and other than with respect to encounters that are incident to services involved) with the individual involved during the 6-month period

preceding such written order, or other reasonable timeframe as determined by the Secretary.''.

(c) APPLICATION TO OTHER AREAS UNDER MEDICARE.—The Secretary may apply the face-to-face encounter requirement described in the amendments made by subsections (a) and (b) to other items and services for which payment is provided under title XVIII of the Social Security Act based upon a finding that such an decision would reduce the risk of waste, fraud, or abuse.

(d) APPLICATION TO MEDICAID.—The requirements pursuant to the amendments made by subsections (a) and (b) shall apply in the case of physicians making certifications for home health services under title XIX of the Social Security Act in the same manner and to the same extent as such requirements apply in the case of physicians making such certifications under title XVIII of such Act.

SEC. 6408. ENHANCED PENALTIES.

(a) CIVIL MONETARY PENALTIES FOR FALSE STATEMENTS OR DELAYING INSPECTIONS.—Section 1128A(a) of the Social Security Act (42 U.S.C. 1320a–7a(a)), as amended by section 5002(d)(2)(A), is amended—

(1) in paragraph (6), by striking ''or'' at the end; and

(2) by inserting after paragraph (7) the following new paragraphs:

''(8) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim for payment for items and services furnished under a Federal health care program; or

''(9) fails to grant timely access, upon reasonable request (as defined by the Secretary in regulations), to the Inspector General of the Department of Health and Human Services, for the purpose of audits, investigations, evaluations, or other statutory functions of the Inspector General of the Department of Health and Human Services;''; and

(3) in the first sentence—

(A) by striking ''or in cases under paragraph (7)'' and inserting ''in cases under paragraph (7)''; and

(B) by striking ''act)'' and inserting ''act, in cases under paragraph (8), $50,000 for each false record or statement, or in cases under paragraph (9), $15,000 for each day of the failure described in such paragraph)''.

(b) MEDICARE ADVANTAGE AND PART D PLANS.—

1 (1) ENSURING TIMELY INSPECTIONS RELATING
2 TO CONTRACTS WITH MA ORGANIZATIONS.—Section
3 1857(d)(2) of such Act (42 U.S.C. 1395w–27(d)(2))
4 is amended—
5 (A) in subparagraph (A), by inserting
6 ''timely'' before ''inspect''; and
7 (B) in subparagraph (B), by inserting
8 ''timely'' before ''audit and inspect''.
9 (2) MARKETING VIOLATIONS.—Section
10 1857(g)(1) of the Social Security Act (42 U.S.C.
11 1395w—27(g)(1)) is amended—
12 (A) in subparagraph (F), by striking ''or''
13 at the end;
14 (B) by inserting after subparagraph (G)
15 the following new subparagraphs:
16 ''(H) except as provided under subpara-
17 graph (C) or (D) of section 1860D–1(b)(1), en-
18 rolls an individual in any plan under this part
19 without the prior consent of the individual or
20 the designee of the individual;
21 ''(I) transfers an individual enrolled under
22 this part from one plan to another without the
23 prior consent of the individual or the designee
24 of the individual or solely for the purpose of
25 earning a commission;

"(J) fails to comply with marketing restrictions described in subsections (h) and (j) of section 1851 or applicable implementing regulations or guidance; or

"(K) employs or contracts with any individual or entity who engages in the conduct described in subparagraphs (A) through (J) of this paragraph;"; and

(C) by adding at the end the following new sentence: "The Secretary may provide, in addition to any other remedies authorized by law, for any of the remedies described in paragraph (2), if the Secretary determines that any employee or agent of such organization, or any provider or supplier who contracts with such organization, has engaged in any conduct described in subparagraphs (A) through (K) of this paragraph.".

(3) PROVISION OF FALSE INFORMATION.—Section 1857(g)(2)(A) of the Social Security Act (42 U.S.C. 1395w—27(g)(2)(A)) is amended by inserting "except with respect to a determination under subparagraph (E), an assessment of not more than the amount claimed by such plan or plan sponsor based upon the misrepresentation or falsified infor-

mation involved,'' after ''for each such determination,''.

(c) OBSTRUCTION OF PROGRAM AUDITS.—Section 1128(b)(2) of the Social Security Act (42 U.S.C. 1320a–7(b)(2)) is amended—

(1) in the heading, by inserting ''OR AUDIT'' after ''INVESTIGATION''; and

(2) by striking ''investigation into'' and all that follows through the period and inserting ''investigation or audit related to—''

''(i) any offense described in paragraph (1) or in subsection (a); or

''(ii) the use of funds received, directly or indirectly, from any Federal health care program (as defined in section 1128B(f)).''.

(d) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall apply to acts committed on or after January 1, 2010.

(2) EXCEPTION.—The amendments made by subsection (b)(1) take effect on the date of enactment of this Act.

SEC. 6409. MEDICARE SELF-REFERRAL DISCLOSURE PROTOCOL.

(a) DEVELOPMENT OF SELF-REFERRAL DISCLOSURE PROTOCOL.—

(1) IN GENERAL.—The Secretary of Health and Human Services, in cooperation with the Inspector General of the Department of Health and Human Services, shall establish, not later than 6 months after the date of the enactment of this Act, a protocol to enable health care providers of services and suppliers to disclose an actual or potential violation of section 1877 of the Social Security Act (42 U.S.C. 1395nn) pursuant to a self-referral disclosure protocol (in this section referred to as an ''SRDP''). The SRDP shall include direction to health care providers of services and suppliers on—

(A) a specific person, official, or office to whom such disclosures shall be made; and

(B) instruction on the implication of the SRDP on corporate integrity agreements and corporate compliance agreements.

(2) PUBLICATION ON INTERNET WEBSITE OF SRDP INFORMATION.—The Secretary of Health and Human Services shall post information on the public Internet website of the Centers for Medicare & Medicaid Services to inform relevant stakeholders of how

to disclose actual or potential violations pursuant to an SRDP.

(3) RELATION TO ADVISORY OPINIONS.—The SRDP shall be separate from the advisory opinion process set forth in regulations implementing section 1877(g) of the Social Security Act.

(b) REDUCTION IN AMOUNTS OWED.—The Secretary of Health and Human Services is authorized to reduce the amount due and owing for all violations under section 1877 of the Social Security Act to an amount less than that specified in subsection (g) of such section. In establishing such amount for a violation, the Secretary may consider the following factors:

(1) The nature and extent of the improper or illegal practice.

(2) The timeliness of such self-disclosure.

(3) The cooperation in providing additional information related to the disclosure.

(4) Such other factors as the Secretary considers appropriate.

(c) REPORT.—Not later than 18 months after the date on which the SRDP protocol is established under subsection (a)(1), the Secretary shall submit to Congress a report on the implementation of this section. Such report shall include—

(1) the number of health care providers of services and suppliers making disclosures pursuant to the SRDP;

(2) the amounts collected pursuant to the SRDP;

(3) the types of violations reported under the SRDP; and

(4) such other information as may be necessary to evaluate the impact of this section.

SEC. 6410. ADJUSTMENTS TO THE MEDICARE DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES COMPETITIVE ACQUISITION PROGRAM.

(a) EXPANSION OF ROUND 2 OF THE DME COMPETITIVE BIDDING PROGRAM.—Section 1847(a)(1) of the Social Security Act (42 U.S.C. 1395w–3(a)(1)) is amended—

(1) in subparagraph (B)(i)(II), by striking ''70'' and inserting ''91''; and

(2) in subparagraph (D)(ii)—

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

(B) by redesignating subclause (II) as subclause (III); and

(C) by inserting after subclause (I) the following new subclause:

"(II) the Secretary shall include the next 21 largest metropolitan statistical areas by total population (after those selected under subclause (I)) for such round; and".

(b) REQUIREMENT TO EITHER COMPETITIVELY BID AREAS OR USE COMPETITIVE BID PRICES BY 2016.—Section 1834(a)(1)(F) of the Social Security Act (42 U.S.C. 1395m(a)(1)(F)) is amended—

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

(2) in clause (ii)—

(A) by inserting "(and, in the case of covered items furnished on or after January 1, 2016, subject to clause (iii), shall)" after "may"; and

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

(3) by adding at the end the following new clause:

"(iii) in the case of covered items furnished on or after January 1, 2016, the Secretary shall continue to make such adjustments described in clause (ii) as, under

such competitive acquisition programs, additional covered items are phased in or information is updated as contracts under section 1847 are recompeted in accordance with section 1847(b)(3)(B).''.

SEC. 6411. EXPANSION OF THE RECOVERY AUDIT CONTRACTOR (RAC) PROGRAM.

(a) EXPANSION TO MEDICAID.—

(1) STATE PLAN AMENDMENT.—Section 1902(a)(42) of the Social Security Act (42 U.S.C. 1396a(a)(42)) is amended—

(A) by striking ''that the records'' and inserting ''that—

''(A) the records'';

(B) by inserting ''and'' after the semicolon; and

(C) by adding at the end the following:

''(B) not later than December 31, 2010, the State shall—

''(i) establish a program under which the State contracts (consistent with State law and in the same manner as the Secretary enters into contracts with recovery audit contractors under section 1893(h), subject to such exceptions or requirements

as the Secretary may require for purposes of this title or a particular State) with 1 or more recovery audit contractors for the purpose of identifying underpayments and overpayments and recouping overpayments under the State plan and under any waiver of the State plan with respect to all services for which payment is made to any entity under such plan or waiver; and

''(ii) provide assurances satisfactory to the Secretary that—

''(I) under such contracts, payment shall be made to such a contractor only from amounts recovered;

''(II) from such amounts recovered, payment—

''(aa) shall be made on a contingent basis for collecting overpayments; and

''(bb) may be made in such amounts as the State may specify for identifying underpayments;

''(III) the State has an adequate process for entities to appeal any ad-

verse determination made by such contractors; and

"(IV) such program is carried out in accordance with such requirements as the Secretary shall specify, including—

"(aa) for purposes of section 1903(a)(7), that amounts expended by the State to carry out the program shall be considered amounts expended as necessary for the proper and efficient administration of the State plan or a waiver of the plan;

"(bb) that section 1903(d) shall apply to amounts recovered under the program; and

"(cc) that the State and any such contractors under contract with the State shall coordinate such recovery audit efforts with other contractors or entities performing audits of entities receiving payments under the State plan or waiver in the State, in-

1 cluding efforts with Federal and
2 State law enforcement with re-
3 spect to the Department of Jus-
4 tice, including the Federal Bu-
5 reau of Investigations, the In-
6 spector General of the Depart-
7 ment of Health and Human
8 Services, and the State medicaid
9 fraud control unit; and''.
10 (2) COORDINATION; REGULATIONS.—
11 (A) IN GENERAL.—The Secretary of
12 Health and Human Services, acting through the
13 Administrator of the Centers for Medicare &
14 Medicaid Services, shall coordinate the expan-
15 sion of the Recovery Audit Contractor program
16 to Medicaid with States, particularly with re-
17 spect to each State that enters into a contract
18 with a recovery audit contractor for purposes of
19 the State's Medicaid program prior to Decem-
20 ber 31, 2010.
21 (B) REGULATIONS.—The Secretary of
22 Health and Human Services shall promulgate
23 regulations to carry out this subsection and the
24 amendments made by this subsection, including

with respect to conditions of Federal financial participation, as specified by the Secretary.

(b) EXPANSION TO MEDICARE PARTS C AND D.—Section 1893(h) of the Social Security Act (42 U.S.C. 1395ddd(h)) is amended—

(1) in paragraph (1), in the matter preceding subparagraph (A), by striking ''part A or B'' and inserting ''this title'';

(2) in paragraph (2), by striking ''parts A and B'' and inserting ''this title'';

(3) in paragraph (3), by inserting ''(not later than December 31, 2010, in the case of contracts relating to payments made under part C or D)'' after ''2010'';

(4) in paragraph (4), in the matter preceding subparagraph (A), by striking ''part A or B'' and inserting ''this title''; and

(5) by adding at the end the following:

''(9) SPECIAL RULES RELATING TO PARTS C AND D.—The Secretary shall enter into contracts under paragraph (1) to require recovery audit contractors to—

''(A) ensure that each MA plan under part C has an anti- fraud plan in effect and to re-

1 view the effectiveness of each such anti-fraud
2 plan;
3 "(B) ensure that each prescription drug
4 plan under part D has an anti- fraud plan in
5 effect and to review the effectiveness of each
6 such anti-fraud plan;
7 "(C) examine claims for reinsurance pay-
8 ments under section 1860D–15(b) to determine
9 whether prescription drug plans submitting
10 such claims incurred costs in excess of the al-
11 lowable reinsurance costs permitted under para-
12 graph (2) of that section; and
13 "(D) review estimates submitted by pre-
14 scription drug plans by private plans with re-
15 spect to the enrollment of high cost bene-
16 ficiaries (as defined by the Secretary) and to
17 compare such estimates with the numbers of
18 such beneficiaries actually enrolled by such
19 plans.".
20 (c) ANNUAL REPORT.—The Secretary of Health and
21 Human Services, acting through the Administrator of the
22 Centers for Medicare & Medicaid Services, shall submit
23 an annual report to Congress concerning the effectiveness
24 of the Recovery Audit Contractor program under Medicaid

and Medicare and shall include such reports recommendations for expanding or improving the program.

Subtitle F—Additional Medicaid Program Integrity Provisions

SEC. 6501. TERMINATION OF PROVIDER PARTICIPATION UNDER MEDICAID IF TERMINATED UNDER MEDICARE OR OTHER STATE PLAN.

Section 1902(a)(39) of the Social Security Act (42 U.S.C. 42 U.S.C. 1396a(a)) is amended by inserting after ''1128A,'' the following: ''terminate the participation of any individual or entity in such program if (subject to such exceptions as are permitted with respect to exclusion under sections 1128(c)(3)(B) and 1128(d)(3)(B)) participation of such individual or entity is terminated under title XVIII or any other State plan under this title,''.

SEC. 6502. MEDICAID EXCLUSION FROM PARTICIPATION RELATING TO CERTAIN OWNERSHIP, CONTROL, AND MANAGEMENT AFFILIATIONS.

Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by section 6401(b), is amended by inserting after paragraph (77) the following:

''(78) provide that the State agency described in paragraph (9) exclude, with respect to a period, any individual or entity from participation in the program under the State plan if such individual or

entity owns, controls, or manages an entity that (or if such entity is owned, controlled, or managed by an individual or entity that)—

"(A) has unpaid overpayments (as defined by the Secretary) under this title during such period determined by the Secretary or the State agency to be delinquent;

"(B) is suspended or excluded from participation under or whose participation is terminated under this title during such period; or

"(C) is affiliated with an individual or entity that has been suspended or excluded from participation under this title or whose participation is terminated under this title during such period;".

SEC. 6503. BILLING AGENTS, CLEARINGHOUSES, OR OTHER ALTERNATE PAYEES REQUIRED TO REGISTER UNDER MEDICAID.

(a) IN GENERAL.—Section 1902(a) of the Social Security Act (42 U.S.C. 42 U.S.C. 1396a(a)), as amended by section 6502(a), is amended by inserting after paragraph (78), the following:

"(79) provide that any agent, clearinghouse, or other alternate payee (as defined by the Secretary) that submits claims on behalf of a health care pro-

vider must register with the State and the Secretary in a form and manner specified by the Secretary;''.

SEC. 6504. REQUIREMENT TO REPORT EXPANDED SET OF DATA ELEMENTS UNDER MMIS TO DETECT FRAUD AND ABUSE.

(a) IN GENERAL.—Section 1903(r)(1)(F) of the Social Security Act (42 U.S.C. 1396b(r)(1)(F)) is amended by inserting after ''necessary'' the following: ''and including, for data submitted to the Secretary on or after January 1, 2010, data elements from the automated data system that the Secretary determines to be necessary for program integrity, program oversight, and administration, at such frequency as the Secretary shall determine''.

(b) MANAGED CARE ORGANIZATIONS.—

(1) IN GENERAL.—Section 1903(m)(2)(A)(xi) of the Social Security Act (42 U.S.C. 1396b(m)(2)(A)(xi)) is amended by inserting ''and for the provision of such data to the State at a frequency and level of detail to be specified by the Secretary'' after ''patients''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply with respect to contract years beginning on or after January 1, 2010.

SEC. 6505. PROHIBITION ON PAYMENTS TO INSTITUTIONS OR ENTITIES LOCATED OUTSIDE OF THE UNITED STATES.

Section 1902(a) of the Social Security Act (42 U.S.C. 1396b(a)), as amended by section 6503, is amended by inserting after paragraph (79) the following new paragraph:

"(80) provide that the State shall not provide any payments for items or services provided under the State plan or under a waiver to any financial institution or entity located outside of the United States;".

SEC. 6506. OVERPAYMENTS.

(a) EXTENSION OF PERIOD FOR COLLECTION OF OVERPAYMENTS DUE TO FRAUD.—

(1) IN GENERAL.—Section 1903(d)(2) of the Social Security Act (42 U.S.C. 1396b(d)(2)) is amended—

(A) in subparagraph (C)—

(i) in the first sentence, by striking "60 days" and inserting "1 year"; and

(ii) in the second sentence, by striking "60 days" and inserting "1-year period"; and

(B) in subparagraph (D)—

(i) in inserting "(i)" after "(D)"; and

(ii) by adding at the end the following:

"(ii) In any case where the State is unable to recover a debt which represents an overpayment (or any portion thereof) made to a person or other entity due to fraud within 1 year of discovery because there is not a final determination of the amount of the overpayment under an administrative or judicial process (as applicable), including as a result of a judgment being under appeal, no adjustment shall be made in the Federal payment to such State on account of such overpayment (or portion thereof) before the date that is 30 days after the date on which a final judgment (including, if applicable, a final determination on an appeal) is made.".

(2) EFFECTIVE DATE.—The amendments made by this subsection take effect on the date of enactment of this Act and apply to overpayments discovered on or after that date.

(b) CORRECTIVE ACTION.—The Secretary shall promulgate regulations that require States to correct Federally identified claims overpayments, of an ongoing or recurring nature, with new Medicaid Management Information System (MMIS) edits, audits, or other appropriate corrective action.

SEC. 6507. MANDATORY STATE USE OF NATIONAL CORRECT CODING INITIATIVE.

Section 1903(r) of the Social Security Act (42 U.S.C. 1396b(r)) is amended—

(1) in paragraph (1)(B)—

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

(B) in clause (iii), by adding ''and'' after the semi-colon; and

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

''(iv) effective for claims filed on or after October 1, 2010, incorporate compatible methodologies of the National Correct Coding Initiative administered by the Secretary (or any successor initiative to promote correct coding and to control improper coding leading to inappropriate payment) and such other methodologies of that Initiative (or such other national correct coding methodologies) as the Secretary identifies in accordance with paragraph (4);''; and

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

1 "(4) For purposes of paragraph (1)(B)(iv), the Sec-
2 retary shall do the following:
3 "(A) Not later than September 1, 2010:
4 "(i) Identify those methodologies of the
5 National Correct Coding Initiative administered
6 by the Secretary (or any successor initiative to
7 promote correct coding and to control improper
8 coding leading to inappropriate payment) which
9 are compatible to claims filed under this title.
10 "(ii) Identify those methodologies of such
11 Initiative (or such other national correct coding
12 methodologies) that should be incorporated into
13 claims filed under this title with respect to
14 items or services for which States provide med-
15 ical assistance under this title and no national
16 correct coding methodologies have been estab-
17 lished under such Initiative with respect to title
18 XVIII.
19 "(iii) Notify States of—
20 "(I) the methodologies identified
21 under subparagraphs (A) and (B) (and of
22 any other national correct coding meth-
23 odologies identified under subparagraph
24 (B)); and

"(II) how States are to incorporate such methodologies into claims filed under this title.

"(B) Not later than March 1, 2011, submit a report to Congress that includes the notice to States under clause (iii) of subparagraph (A) and an analysis supporting the identification of the methodologies made under clauses (i) and (ii) of subparagraph (A).".

SEC. 6508. GENERAL EFFECTIVE DATE.

(a) IN GENERAL.—Except as otherwise provided in this subtitle, this subtitle and the amendments made by this subtitle take effect on January 1, 2011, without regard to whether final regulations to carry out such amendments and subtitle have been promulgated by that date.

(b) DELAY IF STATE LEGISLATION REQUIRED.—In the case of a State plan for medical assistance under title XIX of the Social Security Act or a child health plan under title XXI of such Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirement imposed by the amendments made by this subtitle, the State plan or child health plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of

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

Subtitle G—Additional Program Integrity Provisions

SEC. 6601. PROHIBITION ON FALSE STATEMENTS AND REPRESENTATIONS.

(a) PROHIBITION.—Part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131 et seq.) is amended by adding at the end the following:

"SEC. 519. PROHIBITION ON FALSE STATEMENTS AND REPRESENTATIONS.

''No person, in connection with a plan or other arrangement that is multiple employer welfare arrangement described in section 3(40), shall make a false statement or false representation of fact, knowing it to be false, in connection with the marketing or sale of such plan or arrangement, to any employee, any member of an employee organization, any beneficiary, any employer, any employee

organization, the Secretary, or any State, or the representative or agent of any such person, State, or the Secretary, concerning—

"(1) the financial condition or solvency of such plan or arrangement;

"(2) the benefits provided by such plan or arrangement;

"(3) the regulatory status of such plan or other arrangement under any Federal or State law governing collective bargaining, labor management relations, or intern union affairs; or

"(4) the regulatory status of such plan or other arrangement regarding exemption from state regulatory authority under this Act.

This section shall not apply to any plan or arrangement that does not fall within the meaning of the term 'multiple employer welfare arrangement' under section 3(40)(A).".

(b) CRIMINAL PENALTIES.—Section 501 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131) is amended—

(1) by inserting "(a)" before "Any person"; and

(2) by adding at the end the following:

"(b) Any person that violates section 519 shall upon conviction be imprisoned not more than 10 years or fined under title 18, United States Code, or both.".

(c) CONFORMING AMENDMENT.—The table of sections for part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding at the end the following:

"Sec. 519. Prohibition on false statement and representations.".

SEC. 6602. CLARIFYING DEFINITION.

Section 24(a)(2) of title 18, United States Code, is amended by inserting "or section 411, 518, or 511 of the Employee Retirement Income Security Act of 1974," after "1954 of this title".

SEC. 6603. DEVELOPMENT OF MODEL UNIFORM REPORT FORM.

Part C of title XXVII of the Public Health Service Act (42 U.S.C. 300gg-91 et seq.) is amended by adding at the end the following:

"SEC. 2794. UNIFORM FRAUD AND ABUSE REFERRAL FORMAT.

"The Secretary shall request the National Association of Insurance Commissioners to develop a model uniform report form for private health insurance issuer seeking to refer suspected fraud and abuse to State insurance departments or other responsible State agencies for investigation. The Secretary shall request that the National Association of Insurance Commissioners develop recommendations for uniform reporting standards for such referrals.".

SEC. 6604. APPLICABILITY OF STATE LAW TO COMBAT FRAUD AND ABUSE.

(a) IN GENERAL.—Part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131 et seq.), as amended by section 6601, is further amended by adding at the end the following:

"SEC. 520. APPLICABILITY OF STATE LAW TO COMBAT FRAUD AND ABUSE.

''The Secretary may, for the purpose of identifying, preventing, or prosecuting fraud and abuse, adopt regulatory standards establishing, or issue an order relating to a specific person establishing, that a person engaged in the business of providing insurance through a multiple employer welfare arrangement described in section 3(40) is subject to the laws of the States in which such person operates which regulate insurance in such State, notwithstanding section 514(b)(6) of this Act or the Liability Risk Retention Act of 1986, and regardless of whether the law of the State is otherwise preempted under any of such provisions. This section shall not apply to any plan or arrangement that does not fall within the meaning of the term 'multiple employer welfare arrangement' under section 3(40(A).''.

(b) CONFORMING AMENDMENT.—The table of sections for part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, as amended by

section 6601, is further amended by adding at the end the following:

"Sec. 520. Applicability of State law to combat fraud and abuse.".

SEC. 6605. ENABLING THE DEPARTMENT OF LABOR TO ISSUE ADMINISTRATIVE SUMMARY CEASE AND DESIST ORDERS AND SUMMARY SEIZURES ORDERS AGAINST PLANS THAT ARE IN FINANCIALLY HAZARDOUS CONDITION.

(a) IN GENERAL.—Part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131 et seq.), as amended by section 6604, is further amended by adding at the end the following:

"SEC. 521. ADMINISTRATIVE SUMMARY CEASE AND DESIST ORDERS AND SUMMARY SEIZURE ORDERS AGAINST MULTIPLE EMPLOYER WELFARE ARRANGEMENTS IN FINANCIALLY HAZARDOUS CONDITION.

"(a) IN GENERAL.—The Secretary may issue a cease and desist (ex parte) order under this title if it appears to the Secretary that the alleged conduct of a multiple employer welfare arrangement described in section 3(40), other than a plan or arrangement described in subsection (g), is fraudulent, or creates an immediate danger to the public safety or welfare, or is causing or can be reasonably expected to cause significant, imminent, and irreparable public injury.

"(b) HEARING.—A person that is adversely affected by the issuance of a cease and desist order under subsection (a) may request a hearing by the Secretary regarding such order. The Secretary may require that a proceeding under this section, including all related information and evidence, be conducted in a confidential manner.

"(c) BURDEN OF PROOF.—The burden of proof in any hearing conducted under subsection (b) shall be on the party requesting the hearing to show cause why the cease and desist order should be set aside.

"(d) DETERMINATION.—Based upon the evidence presented at a hearing under subsection (b), the cease and desist order involved may be affirmed, modified, or set aside by the Secretary in whole or in part.

"(e) SEIZURE.—The Secretary may issue a summary seizure order under this title if it appears that a multiple employer welfare arrangement is in a financially hazardous condition.

"(f) REGULATIONS.—The Secretary may promulgate such regulations or other guidance as may be necessary or appropriate to carry out this section.

"(g) EXCEPTION.—This section shall not apply to any plan or arrangement that does not fall within the meaning of the term 'multiple employer welfare arrangement' under section 3(40(A).".

(b) CONFORMING AMENDMENT.—The table of sections for part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, as amended by section 6604, is further amended by adding at the end the following:

"Sec. 521. Administrative summary cease and desist orders and summary seizure orders against health plans in financially hazardous condition.".

SEC. 6606. MEWA PLAN REGISTRATION WITH DEPARTMENT OF LABOR.

Section 101(g) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1021(g)) is amended—

(1) by striking "Secretary may" and inserting "Secretary shall"; and

(2) by inserting "to register with the Secretary prior to operating in a State and may, by regulation, require such multiple employer welfare arrangements" after "not group health plans".

SEC. 6607. PERMITTING EVIDENTIARY PRIVILEGE AND CONFIDENTIAL COMMUNICATIONS.

Section 504 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1134) is amended by adding at the end the following:

"(d) The Secretary may promulgate a regulation that provides an evidentiary privilege for, and provides for the confidentiality of communications between or among, any

of the following entities or their agents, consultants, or employees:

"(1) A State insurance department.

"(2) A State attorney general.

"(3) The National Association of Insurance Commissioners.

"(4) The Department of Labor.

"(5) The Department of the Treasury.

"(6) The Department of Justice.

"(7) The Department of Health and Human Services.

"(8) Any other Federal or State authority that the Secretary determines is appropriate for the purposes of enforcing the provisions of this title.

"(e) The privilege established under subsection (d) shall apply to communications related to any investigation, audit, examination, or inquiry conducted or coordinated by any of the agencies. A communication that is privileged under subsection (d) shall not waive any privilege otherwise available to the communicating agency or to any person who provided the information that is communicated.".

Subtitle H—Elder Justice Act

SEC. 6701. SHORT TITLE OF SUBTITLE.

This subtitle may be cited as the "Elder Justice Act of 2009".

SEC. 6702. DEFINITIONS.

Except as otherwise specifically provided, any term that is defined in section 2011 of the Social Security Act (as added by section 6703(a)) and is used in this subtitle has the meaning given such term by such section.

SEC. 6703. ELDER JUSTICE.

(a) ELDER JUSTICE.—

(1) IN GENERAL.—Title XX of the Social Security Act (42 U.S.C. 1397 et seq.) is amended—

(A) in the heading, by inserting "**AND ELDER JUSTICE**" after "**SOCIAL SERVICES**";

(B) by inserting before section 2001 the following:

"Subtitle A—Block Grants to States for Social Services";

and

(C) by adding at the end the following:

"Subtitle B—Elder Justice

"SEC. 2011. DEFINITIONS.

"In this subtitle:

"(1) ABUSE.—The term 'abuse' means the knowing infliction of physical or psychological harm or the knowing deprivation of goods or services that are necessary to meet essential needs or to avoid physical or psychological harm.

1 "(2) ADULT PROTECTIVE SERVICES.—The term
2 'adult protective services' means such services pro-
3 vided to adults as the Secretary may specify and in-
4 cludes services such as—
5 "(A) receiving reports of adult abuse, ne-
6 glect, or exploitation;
7 "(B) investigating the reports described in
8 subparagraph (A);
9 "(C) case planning, monitoring, evaluation,
10 and other case work and services; and
11 "(D) providing, arranging for, or facili-
12 tating the provision of medical, social service,
13 economic, legal, housing, law enforcement, or
14 other protective, emergency, or support services.
15 "(3) CAREGIVER.—The term 'caregiver' means
16 an individual who has the responsibility for the care
17 of an elder, either voluntarily, by contract, by receipt
18 of payment for care, or as a result of the operation
19 of law, and means a family member or other indi-
20 vidual who provides (on behalf of such individual or
21 of a public or private agency, organization, or insti-
22 tution) compensated or uncompensated care to an
23 elder who needs supportive services in any setting.
24 "(4) DIRECT CARE.—The term 'direct care'
25 means care by an employee or contractor who pro-

vides assistance or long-term care services to a recipient.

"(5) ELDER.—The term 'elder' means an individual age 60 or older.

"(6) ELDER JUSTICE.—The term 'elder justice' means—

"(A) from a societal perspective, efforts to—

"(i) prevent, detect, treat, intervene in, and prosecute elder abuse, neglect, and exploitation; and

"(ii) protect elders with diminished capacity while maximizing their autonomy; and

"(B) from an individual perspective, the recognition of an elder's rights, including the right to be free of abuse, neglect, and exploitation.

"(7) ELIGIBLE ENTITY.—The term 'eligible entity' means a State or local government agency, Indian tribe or tribal organization, or any other public or private entity that is engaged in and has expertise in issues relating to elder justice or in a field necessary to promote elder justice efforts.

1 "(8) EXPLOITATION.—The term 'exploitation'
2 means the fraudulent or otherwise illegal, unauthor-
3 ized, or improper act or process of an individual, in-
4 cluding a caregiver or fiduciary, that uses the re-
5 sources of an elder for monetary or personal benefit,
6 profit, or gain, or that results in depriving an elder
7 of rightful access to, or use of, benefits, resources,
8 belongings, or assets.
9 "(9) FIDUCIARY.—The term 'fiduciary'—
10 "(A) means a person or entity with the
11 legal responsibility—
12 "(i) to make decisions on behalf of
13 and for the benefit of another person; and
14 "(ii) to act in good faith and with
15 fairness; and
16 "(B) includes a trustee, a guardian, a con-
17 servator, an executor, an agent under a finan-
18 cial power of attorney or health care power of
19 attorney, or a representative payee.
20 "(10) GRANT.—The term 'grant' includes a
21 contract, cooperative agreement, or other mechanism
22 for providing financial assistance.
23 "(11) GUARDIANSHIP.—The term 'guardian-
24 ship' means—

"(A) the process by which a State court determines that an adult individual lacks capacity to make decisions about self-care or property, and appoints another individual or entity known as a guardian, as a conservator, or by a similar term, as a surrogate decisionmaker;

"(B) the manner in which the court-appointed surrogate decisionmaker carries out duties to the individual and the court; or

"(C) the manner in which the court exercises oversight of the surrogate decisionmaker.

"(12) INDIAN TRIBE.—

"(A) IN GENERAL.—The term 'Indian tribe' has the meaning given such term in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b).

"(B) INCLUSION OF PUEBLO AND RANCHERIA.—The term 'Indian tribe' includes any Pueblo or Rancheria.

"(13) LAW ENFORCEMENT.—The term 'law enforcement' means the full range of potential responders to elder abuse, neglect, and exploitation including—

"(A) police, sheriffs, detectives, public safety officers, and corrections personnel;

"(B) prosecutors;

"(C) medical examiners;

"(D) investigators; and

"(E) coroners.

"(14) LONG-TERM CARE.—

"(A) IN GENERAL.—The term 'long-term care' means supportive and health services specified by the Secretary for individuals who need assistance because the individuals have a loss of capacity for self-care due to illness, disability, or vulnerability.

"(B) LOSS OF CAPACITY FOR SELF-CARE.—For purposes of subparagraph (A), the term 'loss of capacity for self-care' means an inability to engage in 1 or more activities of daily living, including eating, dressing, bathing, management of one's financial affairs, and other activities the Secretary determines appropriate.

"(15) LONG-TERM CARE FACILITY.—The term 'long-term care facility' means a residential care provider that arranges for, or directly provides, long-term care.

"(16) NEGLECT.—The term 'neglect' means—

"(A) the failure of a caregiver or fiduciary to provide the goods or services that are nec-

essary to maintain the health or safety of an elder; or

"(B) self-neglect.

"(17) NURSING FACILITY.—

"(A) IN GENERAL.—The term 'nursing facility' has the meaning given such term under section 1919(a).

"(B) INCLUSION OF SKILLED NURSING FACILITY.—The term 'nursing facility' includes a skilled nursing facility (as defined in section 1819(a)).

"(18) SELF-NEGLECT.—The term 'self-neglect' means an adult's inability, due to physical or mental impairment or diminished capacity, to perform essential self-care tasks including—

"(A) obtaining essential food, clothing, shelter, and medical care;

"(B) obtaining goods and services necessary to maintain physical health, mental health, or general safety; or

"(C) managing one's own financial affairs.

"(19) SERIOUS BODILY INJURY.—

"(A) IN GENERAL.—The term 'serious bodily injury' means an injury—

"(i) involving extreme physical pain;

"(ii) involving substantial risk of death;

"(iii) involving protracted loss or impairment of the function of a bodily member, organ, or mental faculty; or

"(iv) requiring medical intervention such as surgery, hospitalization, or physical rehabilitation.

"(B) CRIMINAL SEXUAL ABUSE.—Serious bodily injury shall be considered to have occurred if the conduct causing the injury is conduct described in section 2241 (relating to aggravated sexual abuse) or 2242 (relating to sexual abuse) of title 18, United States Code, or any similar offense under State law.

"(20) SOCIAL.—The term 'social', when used with respect to a service, includes adult protective services.

"(21) STATE LEGAL ASSISTANCE DEVELOPER.—The term 'State legal assistance developer' means an individual described in section 731 of the Older Americans Act of 1965.

"(22) STATE LONG-TERM CARE OMBUDSMAN.—The term 'State Long-Term Care Ombudsman' means the State Long-Term Care Ombudsman de-

1 scribed in section 712(a)(2) of the Older Americans
2 Act of 1965.

3 **"SEC. 2012. GENERAL PROVISIONS.**

4 "(a) PROTECTION OF PRIVACY.—In pursuing activi-
5 ties under this subtitle, the Secretary shall ensure the pro-
6 tection of individual health privacy consistent with the reg-
7 ulations promulgated under section 264(c) of the Health
8 Insurance Portability and Accountability Act of 1996 and
9 applicable State and local privacy regulations.

10 "(b) RULE OF CONSTRUCTION.—Nothing in this sub-
11 title shall be construed to interfere with or abridge an el-
12 der's right to practice his or her religion through reliance
13 on prayer alone for healing when this choice—

14 "(1) is contemporaneously expressed, either
15 orally or in writing, with respect to a specific illness
16 or injury which the elder has at the time of the deci-
17 sion by an elder who is competent at the time of the
18 decision;

19 "(2) is previously set forth in a living will,
20 health care proxy, or other advance directive docu-
21 ment that is validly executed and applied under
22 State law; or

23 "(3) may be unambiguously deduced from the
24 elder's life history.

"PART I—NATIONAL COORDINATION OF ELDER JUSTICE ACTIVITIES AND RESEARCH

"Subpart A—Elder Justice Coordinating Council and Advisory Board on Elder Abuse, Neglect, and Exploitation

"SEC. 2021. ELDER JUSTICE COORDINATING COUNCIL.

''(a) ESTABLISHMENT.—There is established within the Office of the Secretary an Elder Justice Coordinating Council (in this section referred to as the 'Council').

''(b) MEMBERSHIP.—

''(1) IN GENERAL.—The Council shall be composed of the following members:

''(A) The Secretary (or the Secretary's designee).

''(B) The Attorney General (or the Attorney General's designee).

''(C) The head of each Federal department or agency or other governmental entity identified by the Chair referred to in subsection (d) as having responsibilities, or administering programs, relating to elder abuse, neglect, and exploitation.

''(2) REQUIREMENT.—Each member of the Council shall be an officer or employee of the Federal Government.

"(c) VACANCIES.—Any vacancy in the Council shall not affect its powers, but shall be filled in the same manner as the original appointment was made.

"(d) CHAIR.—The member described in subsection (b)(1)(A) shall be Chair of the Council.

"(e) MEETINGS.—The Council shall meet at least 2 times per year, as determined by the Chair.

"(f) DUTIES.—

"(1) IN GENERAL.—The Council shall make recommendations to the Secretary for the coordination of activities of the Department of Health and Human Services, the Department of Justice, and other relevant Federal, State, local, and private agencies and entities, relating to elder abuse, neglect, and exploitation and other crimes against elders.

"(2) REPORT.—Not later than the date that is 2 years after the date of enactment of the Elder Justice Act of 2009 and every 2 years thereafter, the Council shall submit to the Committee on Finance of the Senate and the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives a report that—

"(A) describes the activities and accomplishments of, and challenges faced by—

"(i) the Council; and

"(ii) the entities represented on the Council; and

"(B) makes such recommendations for legislation, model laws, or other action as the Council determines to be appropriate.

"(g) POWERS OF THE COUNCIL.—

"(1) INFORMATION FROM FEDERAL AGENCIES.—Subject to the requirements of section 2012(a), the Council may secure directly from any Federal department or agency such information as the Council considers necessary to carry out this section. Upon request of the Chair of the Council, the head of such department or agency shall furnish such information to the Council.

"(2) POSTAL SERVICES.—The Council may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

"(h) TRAVEL EXPENSES.—The members of the Council shall not receive compensation for the performance of services for the Council. The members shall be allowed travel expenses, including per diem in lieu of sub-

sistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Council. Notwithstanding section 1342 of title 31, United States Code, the Secretary may accept the voluntary and uncompensated services of the members of the Council.

''(i) DETAIL OF GOVERNMENT EMPLOYEES.—Any Federal Government employee may be detailed to the Council without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

''(j) STATUS AS PERMANENT COUNCIL.—Section 14 of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the Council.

''(k) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out this section.

''SEC. 2022. ADVISORY BOARD ON ELDER ABUSE, NEGLECT, AND EXPLOITATION.

''(a) ESTABLISHMENT.—There is established a board to be known as the 'Advisory Board on Elder Abuse, Neglect, and Exploitation' (in this section referred to as the 'Advisory Board') to create short- and long-term multidisciplinary strategic plans for the development of the field

of elder justice and to make recommendations to the Elder Justice Coordinating Council established under section 2021.

"(b) COMPOSITION.—The Advisory Board shall be composed of 27 members appointed by the Secretary from among members of the general public who are individuals with experience and expertise in elder abuse, neglect, and exploitation prevention, detection, treatment, intervention, or prosecution.

"(c) SOLICITATION OF NOMINATIONS.—The Secretary shall publish a notice in the Federal Register soliciting nominations for the appointment of members of the Advisory Board under subsection (b).

"(d) TERMS.—

"(1) IN GENERAL.—Each member of the Advisory Board shall be appointed for a term of 3 years, except that, of the members first appointed—

"(A) 9 shall be appointed for a term of 3 years;

"(B) 9 shall be appointed for a term of 2 years; and

"(C) 9 shall be appointed for a term of 1 year.

"(2) VACANCIES.—

"(A) IN GENERAL.—Any vacancy on the Advisory Board shall not affect its powers, but shall be filled in the same manner as the original appointment was made.

"(B) FILLING UNEXPIRED TERM.—An individual chosen to fill a vacancy shall be appointed for the unexpired term of the member replaced.

"(3) EXPIRATION OF TERMS.—The term of any member shall not expire before the date on which the member's successor takes office.

"(e) ELECTION OF OFFICERS.—The Advisory Board shall elect a Chair and Vice Chair from among its members. The Advisory Board shall elect its initial Chair and Vice Chair at its initial meeting.

"(f) DUTIES.—

"(1) ENHANCE COMMUNICATION ON PROMOTING QUALITY OF, AND PREVENTING ABUSE, NEGLECT, AND EXPLOITATION IN, LONG-TERM CARE.—The Advisory Board shall develop collaborative and innovative approaches to improve the quality of, including preventing abuse, neglect, and exploitation in, long-term care.

1 "(2) COLLABORATIVE EFFORTS TO DEVELOP
2 CONSENSUS AROUND THE MANAGEMENT OF CER-
3 TAIN QUALITY-RELATED FACTORS.—
4 "(A) IN GENERAL.—The Advisory Board
5 shall establish multidisciplinary panels to ad-
6 dress, and develop consensus on, subjects relat-
7 ing to improving the quality of long-term care.
8 At least 1 such panel shall address, and develop
9 consensus on, methods for managing resident-
10 to-resident abuse in long-term care.
11 "(B) ACTIVITIES CONDUCTED.—The multi-
12 disciplinary panels established under subpara-
13 graph (A) shall examine relevant research and
14 data, identify best practices with respect to the
15 subject of the panel, determine the best way to
16 carry out those best practices in a practical and
17 feasible manner, and determine an effective
18 manner of distributing information on such
19 subject.
20 "(3) REPORT.—Not later than the date that is
21 18 months after the date of enactment of the Elder
22 Justice Act of 2009, and annually thereafter, the
23 Advisory Board shall prepare and submit to the
24 Elder Justice Coordinating Council, the Committee
25 on Finance of the Senate, and the Committee on

Ways and Means and the Committee on Energy and Commerce of the House of Representatives a report containing—

"(A) information on the status of Federal, State, and local public and private elder justice activities;

"(B) recommendations (including recommended priorities) regarding—

"(i) elder justice programs, research, training, services, practice, enforcement, and coordination;

"(ii) coordination between entities pursuing elder justice efforts and those involved in related areas that may inform or overlap with elder justice efforts, such as activities to combat violence against women and child abuse and neglect; and

"(iii) activities relating to adult fiduciary systems, including guardianship and other fiduciary arrangements;

"(C) recommendations for specific modifications needed in Federal and State laws (including regulations) or for programs, research, and training to enhance prevention, detection, and treatment (including diagnosis) of, inter-

vention in (including investigation of), and prosecution of elder abuse, neglect, and exploitation;

"(D) recommendations on methods for the most effective coordinated national data collection with respect to elder justice, and elder abuse, neglect, and exploitation; and

"(E) recommendations for a multidisciplinary strategic plan to guide the effective and efficient development of the field of elder justice.

"(g) POWERS OF THE ADVISORY BOARD.—

"(1) INFORMATION FROM FEDERAL AGENCIES.—Subject to the requirements of section 2012(a), the Advisory Board may secure directly from any Federal department or agency such information as the Advisory Board considers necessary to carry out this section. Upon request of the Chair of the Advisory Board, the head of such department or agency shall furnish such information to the Advisory Board.

"(2) SHARING OF DATA AND REPORTS.—The Advisory Board may request from any entity pursuing elder justice activities under the Elder Justice Act of 2009 or an amendment made by that Act,

any data, reports, or recommendations generated in connection with such activities.

"(3) POSTAL SERVICES.—The Advisory Board may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

"(h) TRAVEL EXPENSES.—The members of the Advisory Board shall not receive compensation for the performance of services for the Advisory Board. The members shall be allowed travel expenses for up to 4 meetings per year, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Advisory Board. Notwithstanding section 1342 of title 31, United States Code, the Secretary may accept the voluntary and uncompensated services of the members of the Advisory Board.

"(i) DETAIL OF GOVERNMENT EMPLOYEES.—Any Federal Government employee may be detailed to the Advisory Board without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

"(j) STATUS AS PERMANENT ADVISORY COMMITTEE.—Section 14 of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the advisory board.

"(k) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out this section.

"SEC. 2023. RESEARCH PROTECTIONS.

"(a) GUIDELINES.—The Secretary shall promulgate guidelines to assist researchers working in the area of elder abuse, neglect, and exploitation, with issues relating to human subject protections.

"(b) DEFINITION OF LEGALLY AUTHORIZED REPRESENTATIVE FOR APPLICATION OF REGULATIONS.—For purposes of the application of subpart A of part 46 of title 45, Code of Federal Regulations, to research conducted under this subpart, the term 'legally authorized representative' means, unless otherwise provided by law, the individual or judicial or other body authorized under the applicable law to consent to medical treatment on behalf of another person.

"SEC. 2024. AUTHORIZATION OF APPROPRIATIONS.

"There are authorized to be appropriated to carry out this subpart—

"(1) for fiscal year 2011, $6,500,000; and

"(2) for each of fiscal years 2012 through 2014, $7,000,000.

"Subpart B—Elder Abuse, Neglect, and Exploitation Forensic Centers

"SEC. 2031. ESTABLISHMENT AND SUPPORT OF ELDER ABUSE, NEGLECT, AND EXPLOITATION FORENSIC CENTERS.

"(a) IN GENERAL.—The Secretary, in consultation with the Attorney General, shall make grants to eligible entities to establish and operate stationary and mobile forensic centers, to develop forensic expertise regarding, and provide services relating to, elder abuse, neglect, and exploitation.

"(b) STATIONARY FORENSIC CENTERS.—The Secretary shall make 4 of the grants described in subsection (a) to institutions of higher education with demonstrated expertise in forensics or commitment to preventing or treating elder abuse, neglect, or exploitation, to establish and operate stationary forensic centers.

"(c) MOBILE CENTERS.—The Secretary shall make 6 of the grants described in subsection (a) to appropriate entities to establish and operate mobile forensic centers.

"(d) AUTHORIZED ACTIVITIES.—

"(1) DEVELOPMENT OF FORENSIC MARKERS AND METHODOLOGIES.—An eligible entity that re-

ceives a grant under this section shall use funds made available through the grant to assist in determining whether abuse, neglect, or exploitation occurred and whether a crime was committed and to conduct research to describe and disseminate information on—

"(A) forensic markers that indicate a case in which elder abuse, neglect, or exploitation may have occurred; and

"(B) methodologies for determining, in such a case, when and how health care, emergency service, social and protective services, and legal service providers should intervene and when the providers should report the case to law enforcement authorities.

"(2) DEVELOPMENT OF FORENSIC EXPERTISE.—An eligible entity that receives a grant under this section shall use funds made available through the grant to develop forensic expertise regarding elder abuse, neglect, and exploitation in order to provide medical and forensic evaluation, therapeutic intervention, victim support and advocacy, case review, and case tracking.

"(3) COLLECTION OF EVIDENCE.—The Secretary, in coordination with the Attorney General,

shall use data made available by grant recipients under this section to develop the capacity of geriatric health care professionals and law enforcement to collect forensic evidence, including collecting forensic evidence relating to a potential determination of elder abuse, neglect, or exploitation.

''(e) APPLICATION.—To be eligible to receive a grant under this section, an entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section—

''(1) for fiscal year 2011, $4,000,000;

''(2) for fiscal year 2012, $6,000,000; and

''(3) for each of fiscal years 2013 and 2014, $8,000,000.

"PART II—PROGRAMS TO PROMOTE ELDER JUSTICE

"SEC. 2041. ENHANCEMENT OF LONG-TERM CARE.

''(a) GRANTS AND INCENTIVES FOR LONG-TERM CARE STAFFING.—

''(1) IN GENERAL.—The Secretary shall carry out activities, including activities described in paragraphs (2) and (3), to provide incentives for individ-

uals to train for, seek, and maintain employment providing direct care in long-term care.

"(2) SPECIFIC PROGRAMS TO ENHANCE TRAINING, RECRUITMENT, AND RETENTION OF STAFF.—

"(A) COORDINATION WITH SECRETARY OF LABOR TO RECRUIT AND TRAIN LONG-TERM CARE STAFF.—The Secretary shall coordinate activities under this subsection with the Secretary of Labor in order to provide incentives for individuals to train for and seek employment providing direct care in long-term care.

"(B) CAREER LADDERS AND WAGE OR BENEFIT INCREASES TO INCREASE STAFFING IN LONG-TERM CARE.—

"(i) IN GENERAL.—The Secretary shall make grants to eligible entities to carry out programs through which the entities—

"(I) offer, to employees who provide direct care to residents of an eligible entity or individuals receiving community-based long-term care from an eligible entity, continuing training and varying levels of certification, based on observed clinical care prac-

tices and the amount of time the employees spend providing direct care; and

"(II) provide, or make arrangements to provide, bonuses or other increased compensation or benefits to employees who achieve certification under such a program.

"(ii) APPLICATION.—To be eligible to receive a grant under this subparagraph, an eligible entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require (which may include evidence of consultation with the State in which the eligible entity is located with respect to carrying out activities funded under the grant).

"(iii) AUTHORITY TO LIMIT NUMBER OF APPLICANTS.—Nothing in this subparagraph shall be construed as prohibiting the Secretary from limiting the number of applicants for a grant under this subparagraph.

"(3) SPECIFIC PROGRAMS TO IMPROVE MANAGEMENT PRACTICES.—

"(A) IN GENERAL.—The Secretary shall make grants to eligible entities to enable the entities to provide training and technical assistance.

"(B) AUTHORIZED ACTIVITIES.—An eligible entity that receives a grant under subparagraph (A) shall use funds made available through the grant to provide training and technical assistance regarding management practices using methods that are demonstrated to promote retention of individuals who provide direct care, such as—

"(i) the establishment of standard human resource policies that reward high performance, including policies that provide for improved wages and benefits on the basis of job reviews;

"(ii) the establishment of motivational and thoughtful work organization practices;

"(iii) the creation of a workplace culture that respects and values caregivers and their needs;

"(iv) the promotion of a workplace culture that respects the rights of residents of an eligible entity or individuals receiving community-based long-term care from an eligible entity and results in improved care for the residents or the individuals; and

"(v) the establishment of other programs that promote the provision of high quality care, such as a continuing education program that provides additional hours of training, including on-the-job training, for employees who are certified nurse aides.

"(C) APPLICATION.—To be eligible to receive a grant under this paragraph, an eligible entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require (which may include evidence of consultation with the State in which the eligible entity is located with respect to carrying out activities funded under the grant).

"(D) AUTHORITY TO LIMIT NUMBER OF APPLICANTS.—Nothing in this paragraph shall be construed as prohibiting the Secretary from

limiting the number of applicants for a grant under this paragraph.

"(4) ACCOUNTABILITY MEASURES.—The Secretary shall develop accountability measures to ensure that the activities conducted using funds made available under this subsection benefit individuals who provide direct care and increase the stability of the long-term care workforce.

"(5) DEFINITIONS.—In this subsection:

"(A) COMMUNITY-BASED LONG-TERM CARE.—The term 'community-based long-term care' has the meaning given such term by the Secretary.

"(B) ELIGIBLE ENTITY.—The term 'eligible entity' means the following:

"(i) A long-term care facility.

"(ii) A community-based long-term care entity (as defined by the Secretary).

"(b) CERTIFIED EHR TECHNOLOGY GRANT PROGRAM.—

"(1) GRANTS AUTHORIZED.—The Secretary is authorized to make grants to long-term care facilities for the purpose of assisting such entities in offsetting the costs related to purchasing, leasing, developing, and implementing certified EHR tech-

1 nology (as defined in section 1848(o)(4)) designed to
2 improve patient safety and reduce adverse events
3 and health care complications resulting from medica-
4 tion errors.

5 "(2) USE OF GRANT FUNDS.—Funds provided
6 under grants under this subsection may be used for
7 any of the following:

8 "(A) Purchasing, leasing, and installing
9 computer software and hardware, including
10 handheld computer technologies.

11 "(B) Making improvements to existing
12 computer software and hardware.

13 "(C) Making upgrades and other improve-
14 ments to existing computer software and hard-
15 ware to enable e-prescribing.

16 "(D) Providing education and training to
17 eligible long-term care facility staff on the use
18 of such technology to implement the electronic
19 transmission of prescription and patient infor-
20 mation.

21 "(3) APPLICATION.—

22 "(A) IN GENERAL.—To be eligible to re-
23 ceive a grant under this subsection, a long-term
24 care facility shall submit an application to the
25 Secretary at such time, in such manner, and

1 containing such information as the Secretary
2 may require (which may include evidence of
3 consultation with the State in which the long-
4 term care facility is located with respect to car-
5 rying out activities funded under the grant).

6 "(B) AUTHORITY TO LIMIT NUMBER OF
7 APPLICANTS.—Nothing in this subsection shall
8 be construed as prohibiting the Secretary from
9 limiting the number of applicants for a grant
10 under this subsection.

11 "(4) PARTICIPATION IN STATE HEALTH EX-
12 CHANGES.—A long-term care facility that receives a
13 grant under this subsection shall, where available,
14 participate in activities conducted by a State or a
15 qualified State-designated entity (as defined in sec-
16 tion 3013(f) of the Public Health Service Act) under
17 a grant under section 3013 of the Public Health
18 Service Act to coordinate care and for other pur-
19 poses determined appropriate by the Secretary.

20 "(5) ACCOUNTABILITY MEASURES.—The Sec-
21 retary shall develop accountability measures to en-
22 sure that the activities conducted using funds made
23 available under this subsection help improve patient
24 safety and reduce adverse events and health care
25 complications resulting from medication errors.

1 "(c) ADOPTION OF STANDARDS FOR TRANSACTIONS
2 INVOLVING CLINICAL DATA BY LONG-TERM CARE FA-
3 CILITIES.—
4 "(1) STANDARDS AND COMPATIBILITY.—The
5 Secretary shall adopt electronic standards for the ex-
6 change of clinical data by long-term care facilities,
7 including, where available, standards for messaging
8 and nomenclature. Standards adopted by the Sec-
9 retary under the preceding sentence shall be compat-
10 ible with standards established under part C of title
11 XI, standards established under subsections
12 (b)(2)(B)(i) and (e)(4) of section 1860D–4, stand-
13 ards adopted under section 3004 of the Public
14 Health Service Act, and general health information
15 technology standards.
16 "(2) ELECTRONIC SUBMISSION OF DATA TO
17 THE SECRETARY.—
18 "(A) IN GENERAL.—Not later than 10
19 years after the date of enactment of the Elder
20 Justice Act of 2009, the Secretary shall have
21 procedures in place to accept the optional elec-
22 tronic submission of clinical data by long-term
23 care facilities pursuant to the standards adopt-
24 ed under paragraph (1).

"(B) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to require a long-term care facility to submit clinical data electronically to the Secretary.

"(3) REGULATIONS.—The Secretary shall promulgate regulations to carry out this subsection. Such regulations shall require a State, as a condition of the receipt of funds under this part, to conduct such data collection and reporting as the Secretary determines are necessary to satisfy the requirements of this subsection.

"(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section—

"(1) for fiscal year 2011, $20,000,000;

"(2) for fiscal year 2012, $17,500,000; and

"(3) for each of fiscal years 2013 and 2014, $15,000,000.

"SEC. 2042. ADULT PROTECTIVE SERVICES FUNCTIONS AND GRANT PROGRAMS.

"(a) SECRETARIAL RESPONSIBILITIES.—

"(1) IN GENERAL.—The Secretary shall ensure that the Department of Health and Human Services—

"(A) provides funding authorized by this part to State and local adult protective services offices that investigate reports of the abuse, neglect, and exploitation of elders;

"(B) collects and disseminates data annually relating to the abuse, exploitation, and neglect of elders in coordination with the Department of Justice;

"(C) develops and disseminates information on best practices regarding, and provides training on, carrying out adult protective services;

"(D) conducts research related to the provision of adult protective services; and

"(E) provides technical assistance to States and other entities that provide or fund the provision of adult protective services, including through grants made under subsections (b) and (c).

"(2) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection, $3,000,000 for fiscal year 2011 and $4,000,000 for each of fiscal years 2012 through 2014.

"(b) GRANTS TO ENHANCE THE PROVISION OF ADULT PROTECTIVE SERVICES.—

"(1) ESTABLISHMENT.—There is established an adult protective services grant program under which the Secretary shall annually award grants to States in the amounts calculated under paragraph (2) for the purposes of enhancing adult protective services provided by States and local units of government.

"(2) AMOUNT OF PAYMENT.—

"(A) IN GENERAL.—Subject to the availability of appropriations and subparagraphs (B) and (C), the amount paid to a State for a fiscal year under the program under this subsection shall equal the amount appropriated for that year to carry out this subsection multiplied by the percentage of the total number of elders who reside in the United States who reside in that State.

"(B) GUARANTEED MINIMUM PAYMENT AMOUNT.—

"(i) 50 STATES.—Subject to clause (ii), if the amount determined under subparagraph (A) for a State for a fiscal year is less than 0.75 percent of the amount appropriated for such year, the Secretary

shall increase such determined amount so that the total amount paid under this subsection to the State for the year is equal to 0.75 percent of the amount so appropriated.

"(ii) TERRITORIES.—In the case of a State other than 1 of the 50 States, clause (i) shall be applied as if each reference to '0.75' were a reference to '0.1'.

"(C) PRO RATA REDUCTIONS.—The Secretary shall make such pro rata reductions to the amounts described in subparagraph (A) as are necessary to comply with the requirements of subparagraph (B).

"(3) AUTHORIZED ACTIVITIES.—

"(A) ADULT PROTECTIVE SERVICES.—Funds made available pursuant to this subsection may only be used by States and local units of government to provide adult protective services and may not be used for any other purpose.

"(B) USE BY AGENCY.—Each State receiving funds pursuant to this subsection shall provide such funds to the agency or unit of State

government having legal responsibility for providing adult protective services within the State.

"(C) SUPPLEMENT NOT SUPPLANT.—Each State or local unit of government shall use funds made available pursuant to this subsection to supplement and not supplant other Federal, State, and local public funds expended to provide adult protective services in the State.

"(4) STATE REPORTS.—Each State receiving funds under this subsection shall submit to the Secretary, at such time and in such manner as the Secretary may require, a report on the number of elders served by the grants awarded under this subsection.

"(5) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection, $100,000,000 for each of fiscal years 2011 through 2014.

"(c) STATE DEMONSTRATION PROGRAMS.—

"(1) ESTABLISHMENT.—The Secretary shall award grants to States for the purposes of conducting demonstration programs in accordance with paragraph (2).

"(2) DEMONSTRATION PROGRAMS.—Funds made available pursuant to this subsection may be

used by States and local units of government to conduct demonstration programs that test—

"(A) training modules developed for the purpose of detecting or preventing elder abuse;

"(B) methods to detect or prevent financial exploitation of elders;

"(C) methods to detect elder abuse;

"(D) whether training on elder abuse forensics enhances the detection of elder abuse by employees of the State or local unit of government; or

"(E) other matters relating to the detection or prevention of elder abuse.

"(3) APPLICATION.—To be eligible to receive a grant under this subsection, a State shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

"(4) STATE REPORTS.—Each State that receives funds under this subsection shall submit to the Secretary a report at such time, in such manner, and containing such information as the Secretary may require on the results of the demonstration program conducted by the State using funds made available under this subsection.

"(5) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection, $25,000,000 for each of fiscal years 2011 through 2014.

"SEC. 2043. LONG-TERM CARE OMBUDSMAN PROGRAM GRANTS AND TRAINING.

"(a) GRANTS TO SUPPORT THE LONG-TERM CARE OMBUDSMAN PROGRAM.—

"(1) IN GENERAL.—The Secretary shall make grants to eligible entities with relevant expertise and experience in abuse and neglect in long-term care facilities or long-term care ombudsman programs and responsibilities, for the purpose of—

"(A) improving the capacity of State long-term care ombudsman programs to respond to and resolve complaints about abuse and neglect;

"(B) conducting pilot programs with State long-term care ombudsman offices or local ombudsman entities; and

"(C) providing support for such State long-term care ombudsman programs and such pilot programs (such as through the establishment of a national long-term care ombudsman resource center).

"(2) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection—

"(A) for fiscal year 2011, $5,000,000;

"(B) for fiscal year 2012, $7,500,000; and

"(C) for each of fiscal years 2013 and 2014, $10,000,000.

"(b) OMBUDSMAN TRAINING PROGRAMS.—

"(1) IN GENERAL.—The Secretary shall establish programs to provide and improve ombudsman training with respect to elder abuse, neglect, and exploitation for national organizations and State long-term care ombudsman programs.

"(2) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection, for each of fiscal years 2011 through 2014, $10,000,000.

"SEC. 2044. PROVISION OF INFORMATION REGARDING, AND EVALUATIONS OF, ELDER JUSTICE PROGRAMS.

"(a) PROVISION OF INFORMATION.—To be eligible to receive a grant under this part, an applicant shall agree—

"(1) except as provided in paragraph (2), to provide the eligible entity conducting an evaluation under subsection (b) of the activities funded through

the grant with such information as the eligible entity may require in order to conduct such evaluation; or

"(2) in the case of an applicant for a grant under section 2041(b), to provide the Secretary with such information as the Secretary may require to conduct an evaluation or audit under subsection (c).

"(b) USE OF ELIGIBLE ENTITIES TO CONDUCT EVALUATIONS.—

"(1) EVALUATIONS REQUIRED.—Except as provided in paragraph (2), the Secretary shall—

"(A) reserve a portion (not less than 2 percent) of the funds appropriated with respect to each program carried out under this part; and

"(B) use the funds reserved under subparagraph (A) to provide assistance to eligible entities to conduct evaluations of the activities funded under each program carried out under this part.

"(2) CERTIFIED EHR TECHNOLOGY GRANT PROGRAM NOT INCLUDED.—The provisions of this subsection shall not apply to the certified EHR technology grant program under section 2041(b).

"(3) AUTHORIZED ACTIVITIES.—A recipient of assistance described in paragraph (1)(B) shall use the funds made available through the assistance to

1 conduct a validated evaluation of the effectiveness of
2 the activities funded under a program carried out
3 under this part.

4 "(4) APPLICATIONS.—To be eligible to receive
5 assistance under paragraph (1)(B), an entity shall
6 submit an application to the Secretary at such time,
7 in such manner, and containing such information as
8 the Secretary may require, including a proposal for
9 the evaluation.

10 "(5) REPORTS.—Not later than a date specified
11 by the Secretary, an eligible entity receiving assist-
12 ance under paragraph (1)(B) shall submit to the
13 Secretary, the Committee on Ways and Means and
14 the Committee on Energy and Commerce of the
15 House of Representatives, and the Committee on Fi-
16 nance of the Senate a report containing the results
17 of the evaluation conducted using such assistance to-
18 gether with such recommendations as the entity de-
19 termines to be appropriate.

20 "(c) EVALUATIONS AND AUDITS OF CERTIFIED EHR
21 TECHNOLOGY GRANT PROGRAM BY THE SECRETARY.—

22 "(1) EVALUATIONS.—The Secretary shall con-
23 duct an evaluation of the activities funded under the
24 certified EHR technology grant program under sec-
25 tion 2041(b). Such evaluation shall include an eval-

uation of whether the funding provided under the grant is expended only for the purposes for which it is made.

"(2) AUDITS.—The Secretary shall conduct appropriate audits of grants made under section 2041(b).

"SEC. 2045. REPORT.

"Not later than October 1, 2014, the Secretary shall submit to the Elder Justice Coordinating Council established under section 2021, the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives, and the Committee on Finance of the Senate a report—

"(1) compiling, summarizing, and analyzing the information contained in the State reports submitted under subsections (b)(4) and (c)(4) of section 2042; and

"(2) containing such recommendations for legislative or administrative action as the Secretary determines to be appropriate.

"SEC. 2046. RULE OF CONSTRUCTION.

"Nothing in this subtitle shall be construed as—

"(1) limiting any cause of action or other relief related to obligations under this subtitle that is

available under the law of any State, or political subdivision thereof; or

"(2) creating a private cause of action for a violation of this subtitle.".

(2) OPTION FOR STATE PLAN UNDER PROGRAM FOR TEMPORARY ASSISTANCE FOR NEEDY FAMILIES.—

(A) IN GENERAL.—Section 402(a)(1)(B) of the Social Security Act (42 U.S.C. 602(a)(1)(B)) is amended by adding at the end the following new clause:

"(v) The document shall indicate whether the State intends to assist individuals to train for, seek, and maintain employment—

"(I) providing direct care in a long-term care facility (as such terms are defined under section 2011); or

"(II) in other occupations related to elder care determined appropriate by the State for which the State identifies an unmet need for service personnel,

and, if so, shall include an overview of such assistance.".

(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) shall take effect on January 1, 2011.

(b) PROTECTING RESIDENTS OF LONG-TERM CARE FACILITIES.—

(1) NATIONAL TRAINING INSTITUTE FOR SURVEYORS.—

(A) IN GENERAL.—The Secretary of Health and Human Services shall enter into a contract with an entity for the purpose of establishing and operating a National Training Institute for Federal and State surveyors. Such Institute shall provide and improve the training of surveyors with respect to investigating allegations of abuse, neglect, and misappropriation of property in programs and long-term care facilities that receive payments under title XVIII or XIX of the Social Security Act.

(B) ACTIVITIES CARRIED OUT BY THE INSTITUTE.—The contract entered into under subparagraph (A) shall require the Institute established and operated under such contract to carry out the following activities:

(i) Assess the extent to which State agencies use specialized surveyors for the

investigation of reported allegations of abuse, neglect, and misappropriation of property in such programs and long-term care facilities.

(ii) Evaluate how the competencies of surveyors may be improved to more effectively investigate reported allegations of such abuse, neglect, and misappropriation of property, and provide feedback to Federal and State agencies on the evaluations conducted.

(iii) Provide a national program of training, tools, and technical assistance to Federal and State surveyors on investigating reports of such abuse, neglect, and misappropriation of property.

(iv) Develop and disseminate information on best practices for the investigation of such abuse, neglect, and misappropriation of property.

(v) Assess the performance of State complaint intake systems, in order to ensure that the intake of complaints occurs 24 hours per day, 7 days a week (including holidays).

(vi) To the extent approved by the Secretary of Health and Human Services, provide a national 24 hours per day, 7 days a week (including holidays), back-up system to State complaint intake systems in order to ensure optimum national responsiveness to complaints of such abuse, neglect, and misappropriation of property.

(vii) Analyze and report annually on the following:

(I) The total number and sources of complaints of such abuse, neglect, and misappropriation of property.

(II) The extent to which such complaints are referred to law enforcement agencies.

(III) General results of Federal and State investigations of such complaints.

(viii) Conduct a national study of the cost to State agencies of conducting complaint investigations of skilled nursing facilities and nursing facilities under sections 1819 and 1919, respectively, of the Social Security Act (42 U.S.C. 1395i–3; 1396r),

and making recommendations to the Secretary of Health and Human Services with respect to options to increase the efficiency and cost-effectiveness of such investigations.

(C) AUTHORIZATION.—There are authorized to be appropriated to carry out this paragraph, for the period of fiscal years 2011 through 2014, $12,000,000.

(2) GRANTS TO STATE SURVEY AGENCIES.—

(A) IN GENERAL.—The Secretary of Health and Human Services shall make grants to State agencies that perform surveys of skilled nursing facilities or nursing facilities under sections 1819 or 1919, respectively, of the Social Security Act (42 U.S.C. 1395i–3; 1395r).

(B) USE OF FUNDS.—A grant awarded under subparagraph (A) shall be used for the purpose of designing and implementing complaint investigations systems that—

(i) promptly prioritize complaints in order to ensure a rapid response to the most serious and urgent complaints;

(ii) respond to complaints with optimum effectiveness and timeliness; and

(iii) optimize the collaboration between local authorities, consumers, and providers, including—

(I) such State agency;

(II) the State Long-Term Care Ombudsman;

(III) local law enforcement agencies;

(IV) advocacy and consumer organizations;

(V) State aging units;

(VI) Area Agencies on Aging; and

(VII) other appropriate entities.

(C) AUTHORIZATION.—There are authorized to be appropriated to carry out this paragraph, for each of fiscal years 2011 through 2014, $5,000,000.

(3) REPORTING OF CRIMES IN FEDERALLY FUNDED LONG-TERM CARE FACILITIES.—Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.), as amended by section 6005, is amended by

1 inserting after section 1150A the following new sec-
2 tion:

3 "REPORTING TO LAW ENFORCEMENT OF CRIMES OCCUR-
4 RING IN FEDERALLY FUNDED LONG-TERM CARE FA-
5 CILITIES

6 "SEC. 1150B. (a) DETERMINATION AND NOTIFICA-
7 TION.—

8 "(1) DETERMINATION.—The owner or operator
9 of each long-term care facility that receives Federal
10 funds under this Act shall annually determine
11 whether the facility received at least $10,000 in such
12 Federal funds during the preceding year.

13 "(2) NOTIFICATION.—If the owner or operator
14 determines under paragraph (1) that the facility re-
15 ceived at least $10,000 in such Federal funds during
16 the preceding year, such owner or operator shall an-
17 nually notify each covered individual (as defined in
18 paragraph (3)) of that individual's obligation to
19 comply with the reporting requirements described in
20 subsection (b).

21 "(3) COVERED INDIVIDUAL DEFINED.—In this
22 section, the term 'covered individual' means each in-
23 dividual who is an owner, operator, employee, man-
24 ager, agent, or contractor of a long-term care facility
25 that is the subject of a determination described in
26 paragraph (1).

1 "(b) REPORTING REQUIREMENTS.—

2 "(1) IN GENERAL.—Each covered individual
3 shall report to the Secretary and 1 or more law en-
4 forcement entities for the political subdivision in
5 which the facility is located any reasonable suspicion
6 of a crime (as defined by the law of the applicable
7 political subdivision) against any individual who is a
8 resident of, or is receiving care from, the facility.

9 "(2) TIMING.—If the events that cause the sus-
10 picion—

11 "(A) result in serious bodily injury, the in-
12 dividual shall report the suspicion immediately,
13 but not later than 2 hours after forming the
14 suspicion; and

15 "(B) do not result in serious bodily injury,
16 the individual shall report the suspicion not
17 later than 24 hours after forming the suspicion.

18 "(c) PENALTIES.—

19 "(1) IN GENERAL.—If a covered individual vio-
20 lates subsection (b)—

21 "(A) the covered individual shall be subject
22 to a civil money penalty of not more than
23 $200,000; and

24 "(B) the Secretary may make a determina-
25 tion in the same proceeding to exclude the cov-

ered individual from participation in any Federal health care program (as defined in section 1128B(f)).

"(2) INCREASED HARM.—If a covered individual violates subsection (b) and the violation exacerbates the harm to the victim of the crime or results in harm to another individual—

"(A) the covered individual shall be subject to a civil money penalty of not more than $300,000; and

"(B) the Secretary may make a determination in the same proceeding to exclude the covered individual from participation in any Federal health care program (as defined in section 1128B(f)).

"(3) EXCLUDED INDIVIDUAL.—During any period for which a covered individual is classified as an excluded individual under paragraph (1)(B) or (2)(B), a long-term care facility that employs such individual shall be ineligible to receive Federal funds under this Act.

"(4) EXTENUATING CIRCUMSTANCES.—

"(A) IN GENERAL.—The Secretary may take into account the financial burden on providers with underserved populations in deter-

1 mining any penalty to be imposed under this
2 subsection.
3 "(B) UNDERSERVED POPULATION DE-
4 FINED.—In this paragraph, the term 'under-
5 served population' means the population of an
6 area designated by the Secretary as an area
7 with a shortage of elder justice programs or a
8 population group designated by the Secretary
9 as having a shortage of such programs. Such
10 areas or groups designated by the Secretary
11 may include—
12 "(i) areas or groups that are geo-
13 graphically isolated (such as isolated in a
14 rural area);
15 "(ii) racial and ethnic minority popu-
16 lations; and
17 "(iii) populations underserved because
18 of special needs (such as language barriers,
19 disabilities, alien status, or age).
20 "(d) ADDITIONAL PENALTIES FOR RETALIATION.—
21 "(1) IN GENERAL.—A long-term care facility
22 may not—
23 "(A) discharge, demote, suspend, threaten,
24 harass, or deny a promotion or other employ-
25 ment-related benefit to an employee, or in any

other manner discriminate against an employee in the terms and conditions of employment because of lawful acts done by the employee; or

"(B) file a complaint or a report against a nurse or other employee with the appropriate State professional disciplinary agency because of lawful acts done by the nurse or employee,

for making a report, causing a report to be made, or for taking steps in furtherance of making a report pursuant to subsection (b)(1).

"(2) PENALTIES FOR RETALIATION.—If a long-term care facility violates subparagraph (A) or (B) of paragraph (1) the facility shall be subject to a civil money penalty of not more than $200,000 or the Secretary may classify the entity as an excluded entity for a period of 2 years pursuant to section 1128(b), or both.

"(3) REQUIREMENT TO POST NOTICE.—Each long-term care facility shall post conspicuously in an appropriate location a sign (in a form specified by the Secretary) specifying the rights of employees under this section. Such sign shall include a statement that an employee may file a complaint with the Secretary against a long-term care facility that violates the provisions of this subsection and informa-

tion with respect to the manner of filing such a complaint.

''(e) PROCEDURE.—The provisions of section 1128A (other than subsections (a) and (b) and the second sentence of subsection (f)) shall apply to a civil money penalty or exclusion under this section in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

''(f) DEFINITIONS.—In this section, the terms 'elder justice', 'long-term care facility', and 'law enforcement' have the meanings given those terms in section 2011.''.

(c) NATIONAL NURSE AIDE REGISTRY.—

(1) DEFINITION OF NURSE AIDE.—In this subsection, the term ''nurse aide'' has the meaning given that term in sections 1819(b)(5)(F) and 1919(b)(5)(F) of the Social Security Act (42 U.S.C. 1395i–3(b)(5)(F); 1396r(b)(5)(F)).

(2) STUDY AND REPORT.—

(A) IN GENERAL.—The Secretary, in consultation with appropriate government agencies and private sector organizations, shall conduct a study on establishing a national nurse aide registry.

1 (B) AREAS EVALUATED.—The study con-
2 ducted under this subsection shall include an
3 evaluation of—
4 (i) who should be included in the reg-
5 istry;
6 (ii) how such a registry would comply
7 with Federal and State privacy laws and
8 regulations;
9 (iii) how data would be collected for
10 the registry;
11 (iv) what entities and individuals
12 would have access to the data collected;
13 (v) how the registry would provide ap-
14 propriate information regarding violations
15 of Federal and State law by individuals in-
16 cluded in the registry;
17 (vi) how the functions of a national
18 nurse aide registry would be coordinated
19 with the nationwide program for national
20 and State background checks on direct pa-
21 tient access employees of long-term care
22 facilities and providers under section 4301;
23 and
24 (vii) how the information included in
25 State nurse aide registries developed and

1 maintained under sections 1819(e)(2) and
2 1919(e)(2) of the Social Security Act (42
3 U.S.C. 1395i–3(e)(2); 1396r(e)(2)(2))
4 would be provided as part of a national
5 nurse aide registry.
6 (C) CONSIDERATIONS.—In conducting the
7 study and preparing the report required under
8 this subsection, the Secretary shall take into
9 consideration the findings and conclusions of
10 relevant reports and other relevant resources,
11 including the following:
12 (i) The Department of Health and
13 Human Services Office of Inspector Gen-
14 eral Report, Nurse Aide Registries: State
15 Compliance and Practices (February
16 2005).
17 (ii) The General Accounting Office
18 (now known as the Government Account-
19 ability Office) Report, Nursing Homes:
20 More Can Be Done to Protect Residents
21 from Abuse (March 2002).
22 (iii) The Department of Health and
23 Human Services Office of the Inspector
24 General Report, Nurse Aide Registries:

1 Long-Term Care Facility Compliance and
2 Practices (July 2005).
3 (iv) The Department of Health and
4 Human Services Health Resources and
5 Services Administration Report, Nursing
6 Aides, Home Health Aides, and Related
7 Health Care Occupations—National and
8 Local Workforce Shortages and Associated
9 Data Needs (2004) (in particular with re-
10 spect to chapter 7 and appendix F).
11 (v) The 2001 Report to CMS from
12 the School of Rural Public Health, Texas
13 A&M University, Preventing Abuse and
14 Neglect in Nursing Homes: The Role of
15 Nurse Aide Registries.
16 (vi) Information included in State
17 nurse aide registries developed and main-
18 tained under sections 1819(e)(2) and
19 1919(e)(2) of the Social Security Act (42
20 U.S.C. 1395i–3(e)(2); 1396r(e)(2)(2)).
21 (D) REPORT.—Not later than 18 months
22 after the date of enactment of this Act, the Sec-
23 retary shall submit to the Elder Justice Coordi-
24 nating Council established under section 2021
25 of the Social Security Act, as added by section

1805(a), the Committee on Finance of the Senate, and the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives a report containing the findings and recommendations of the study conducted under this paragraph.

(E) FUNDING LIMITATION.—Funding for the study conducted under this subsection shall not exceed $500,000.

(3) CONGRESSIONAL ACTION.—After receiving the report submitted by the Secretary under paragraph (2)(D), the Committee on Finance of the Senate and the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives shall, as they deem appropriate, take action based on the recommendations contained in the report.

(4) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary for the purpose of carrying out this subsection.

(d) CONFORMING AMENDMENTS.—

(1) TITLE XX.—Title XX of the Social Security Act (42 U.S.C. 1397 et seq.), as amended by section 6703(a), is amended—

(A) in the heading of section 2001, by striking ''TITLE'' and inserting ''SUBTITLE''; and

(B) in subtitle 1, by striking ''this title'' each place it appears and inserting ''this subtitle''.

(2) TITLE IV.—Title IV of the Social Security Act (42 U.S.C. 601 et seq.) is amended—

(A) in section 404(d)—

(i) in paragraphs (1)(A), (2)(A), and (3)(B), by inserting ''subtitle 1 of'' before ''title XX'' each place it appears;

(ii) in the heading of paragraph (2), by inserting ''SUBTITLE 1 OF'' before ''TITLE XX''; and

(iii) in the heading of paragraph (3)(B), by inserting ''SUBTITLE 1 OF'' before ''TITLE XX''; and

(B) in sections 422(b), 471(a)(4), 472(h)(1), and 473(b)(2), by inserting ''subtitle 1 of'' before ''title XX'' each place it appears.

(3) TITLE XI.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended—

(A) in section 1128(h)(3)—

(i) by inserting ''subtitle 1 of'' before ''title XX''; and

(ii) by striking ''such title'' and inserting ''such subtitle''; and

(B) in section 1128A(i)(1), by inserting ''subtitle 1 of'' before ''title XX''.

Subtitle I—Sense of the Senate Regarding Medical Malpractice

SEC. 6801. SENSE OF THE SENATE REGARDING MEDICAL MALPRACTICE.

It is the sense of the Senate that—

(1) health care reform presents an opportunity to address issues related to medical malpractice and medical liability insurance;

(2) States should be encouraged to develop and test alternatives to the existing civil litigation system as a way of improving patient safety, reducing medical errors, encouraging the efficient resolution of disputes, increasing the availability of prompt and fair resolution of disputes, and improving access to liability insurance, while preserving an individual's right to seek redress in court; and

(3) Congress should consider establishing a State demonstration program to evaluate alter-

natives to the existing civil litigation system with respect to the resolution of medical malpractice claims.

TITLE VII—IMPROVING ACCESS TO INNOVATIVE MEDICAL THERAPIES

Subtitle A—Biologics Price Competition and Innovation

SEC. 7001. SHORT TITLE.

(a) IN GENERAL.—This subtitle may be cited as the ''Biologics Price Competition and Innovation Act of 2009''.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that a biosimilars pathway balancing innovation and consumer interests should be established.

SEC. 7002. APPROVAL PATHWAY FOR BIOSIMILAR BIOLOGICAL PRODUCTS.

(a) LICENSURE OF BIOLOGICAL PRODUCTS AS BIOSIMILAR OR INTERCHANGEABLE.—Section 351 of the Public Health Service Act (42 U.S.C. 262) is amended—

(1) in subsection (a)(1)(A), by inserting ''under this subsection or subsection (k)'' after ''biologics license''; and

(2) by adding at the end the following:

''(k) LICENSURE OF BIOLOGICAL PRODUCTS AS BIOSIMILAR OR INTERCHANGEABLE.—

"(1) IN GENERAL.—Any person may submit an application for licensure of a biological product under this subsection.

"(2) CONTENT.—

"(A) IN GENERAL.—

"(i) REQUIRED INFORMATION.—An application submitted under this subsection shall include information demonstrating that—

"(I) the biological product is biosimilar to a reference product based upon data derived from—

"(aa) analytical studies that demonstrate that the biological product is highly similar to the reference product notwithstanding minor differences in clinically inactive components;

"(bb) animal studies (including the assessment of toxicity); and

"(cc) a clinical study or studies (including the assessment of immunogenicity and pharmacokinetics or

pharmacodynamics) that are sufficient to demonstrate safety, purity, and potency in 1 or more appropriate conditions of use for which the reference product is licensed and intended to be used and for which licensure is sought for the biological product;

''(II) the biological product and reference product utilize the same mechanism or mechanisms of action for the condition or conditions of use prescribed, recommended, or suggested in the proposed labeling, but only to the extent the mechanism or mechanisms of action are known for the reference product;

''(III) the condition or conditions of use prescribed, recommended, or suggested in the labeling proposed for the biological product have been previously approved for the reference product;

''(IV) the route of administration, the dosage form, and the

strength of the biological product are the same as those of the reference product; and

"(V) the facility in which the biological product is manufactured, processed, packed, or held meets standards designed to assure that the biological product continues to be safe, pure, and potent.

"(ii) DETERMINATION BY SECRETARY.—The Secretary may determine, in the Secretary's discretion, that an element described in clause (i)(I) is unnecessary in an application submitted under this subsection.

"(iii) ADDITIONAL INFORMATION.—An application submitted under this subsection—

"(I) shall include publicly-available information regarding the Secretary's previous determination that the reference product is safe, pure, and potent; and

"(II) may include any additional information in support of the applica-

tion, including publicly-available information with respect to the reference product or another biological product.

"(B) INTERCHANGEABILITY.—An application (or a supplement to an application) submitted under this subsection may include information demonstrating that the biological product meets the standards described in paragraph (4).

"(3) EVALUATION BY SECRETARY.—Upon review of an application (or a supplement to an application) submitted under this subsection, the Secretary shall license the biological product under this subsection if—

"(A) the Secretary determines that the information submitted in the application (or the supplement) is sufficient to show that the biological product—

"(i) is biosimilar to the reference product; or

"(ii) meets the standards described in paragraph (4), and therefore is interchangeable with the reference product; and

"(B) the applicant (or other appropriate person) consents to the inspection of the facility

that is the subject of the application, in accordance with subsection (c).

"(4) SAFETY STANDARDS FOR DETERMINING INTERCHANGEABILITY.—Upon review of an application submitted under this subsection or any supplement to such application, the Secretary shall determine the biological product to be interchangeable with the reference product if the Secretary determines that the information submitted in the application (or a supplement to such application) is sufficient to show that—

"(A) the biological product—

"(i) is biosimilar to the reference product; and

"(ii) can be expected to produce the same clinical result as the reference product in any given patient; and

"(B) for a biological product that is administered more than once to an individual, the risk in terms of safety or diminished efficacy of alternating or switching between use of the biological product and the reference product is not greater than the risk of using the reference product without such alternation or switch.

"(5) GENERAL RULES.—

"(A) ONE REFERENCE PRODUCT PER APPLICATION.—A biological product, in an application submitted under this subsection, may not be evaluated against more than 1 reference product.

"(B) REVIEW.—An application submitted under this subsection shall be reviewed by the division within the Food and Drug Administration that is responsible for the review and approval of the application under which the reference product is licensed.

"(C) RISK EVALUATION AND MITIGATION STRATEGIES.—The authority of the Secretary with respect to risk evaluation and mitigation strategies under the Federal Food, Drug, and Cosmetic Act shall apply to biological products licensed under this subsection in the same manner as such authority applies to biological products licensed under subsection (a).

"(6) EXCLUSIVITY FOR FIRST INTERCHANGEABLE BIOLOGICAL PRODUCT.—Upon review of an application submitted under this subsection relying on the same reference product for which a prior biological product has received a determination of interchangeability for any condition of use, the Secretary

shall not make a determination under paragraph (4) that the second or subsequent biological product is interchangeable for any condition of use until the earlier of—

"(A) 1 year after the first commercial marketing of the first interchangeable biosimilar biological product to be approved as interchangeable for that reference product;

"(B) 18 months after—

"(i) a final court decision on all patents in suit in an action instituted under subsection (l)(6) against the applicant that submitted the application for the first approved interchangeable biosimilar biological product; or

"(ii) the dismissal with or without prejudice of an action instituted under subsection (l)(6) against the applicant that submitted the application for the first approved interchangeable biosimilar biological product; or

"(C)(i) 42 months after approval of the first interchangeable biosimilar biological product if the applicant that submitted such application has been sued under subsection (l)(6)

and such litigation is still ongoing within such 42-month period; or

"(ii) 18 months after approval of the first interchangeable biosimilar biological product if the applicant that submitted such application has not been sued under subsection (l)(6).

For purposes of this paragraph, the term 'final court decision' means a final decision of a court from which no appeal (other than a petition to the United States Supreme Court for a writ of certiorari) has been or can be taken.

"(7) EXCLUSIVITY FOR REFERENCE PRODUCT.—

"(A) EFFECTIVE DATE OF BIOSIMILAR APPLICATION APPROVAL.—Approval of an application under this subsection may not be made effective by the Secretary until the date that is 12 years after the date on which the reference product was first licensed under subsection (a).

"(B) FILING PERIOD.—An application under this subsection may not be submitted to the Secretary until the date that is 4 years after the date on which the reference product was first licensed under subsection (a).

"(C) FIRST LICENSURE.—Subparagraphs (A) and (B) shall not apply to a license for or approval of—

"(i) a supplement for the biological product that is the reference product; or

"(ii) a subsequent application filed by the same sponsor or manufacturer of the biological product that is the reference product (or a licensor, predecessor in interest, or other related entity) for—

"(I) a change (not including a modification to the structure of the biological product) that results in a new indication, route of administration, dosing schedule, dosage form, delivery system, delivery device, or strength; or

"(II) a modification to the structure of the biological product that does not result in a change in safety, purity, or potency.

"(8) GUIDANCE DOCUMENTS.—

"(A) IN GENERAL.—The Secretary may, after opportunity for public comment, issue guidance in accordance, except as provided in subparagraph (B)(i), with section 701(h) of the

Federal Food, Drug, and Cosmetic Act with respect to the licensure of a biological product under this subsection. Any such guidance may be general or specific.

"(B) PUBLIC COMMENT.—

"(i) IN GENERAL.—The Secretary shall provide the public an opportunity to comment on any proposed guidance issued under subparagraph (A) before issuing final guidance.

"(ii) INPUT REGARDING MOST VALUABLE GUIDANCE.—The Secretary shall establish a process through which the public may provide the Secretary with input regarding priorities for issuing guidance.

"(C) NO REQUIREMENT FOR APPLICATION CONSIDERATION.—The issuance (or non-issuance) of guidance under subparagraph (A) shall not preclude the review of, or action on, an application submitted under this subsection.

"(D) REQUIREMENT FOR PRODUCT CLASS-SPECIFIC GUIDANCE.—If the Secretary issues product class-specific guidance under subparagraph (A), such guidance shall include a description of—

"(i) the criteria that the Secretary will use to determine whether a biological product is highly similar to a reference product in such product class; and

"(ii) the criteria, if available, that the Secretary will use to determine whether a biological product meets the standards described in paragraph (4).

"(E) CERTAIN PRODUCT CLASSES.—

"(i) GUIDANCE.—The Secretary may indicate in a guidance document that the science and experience, as of the date of such guidance, with respect to a product or product class (not including any recombinant protein) does not allow approval of an application for a license as provided under this subsection for such product or product class.

"(ii) MODIFICATION OR REVERSAL.—The Secretary may issue a subsequent guidance document under subparagraph (A) to modify or reverse a guidance document under clause (i).

"(iii) NO EFFECT ON ABILITY TO DENY LICENSE.—Clause (i) shall not be

construed to require the Secretary to approve a product with respect to which the Secretary has not indicated in a guidance document that the science and experience, as described in clause (i), does not allow approval of such an application.

"(l) PATENTS.—

"(1) CONFIDENTIAL ACCESS TO SUBSECTION (k) APPLICATION.—

"(A) APPLICATION OF PARAGRAPH.—Unless otherwise agreed to by a person that submits an application under subsection (k) (referred to in this subsection as the 'subsection (k) applicant') and the sponsor of the application for the reference product (referred to in this subsection as the 'reference product sponsor'), the provisions of this paragraph shall apply to the exchange of information described in this subsection.

"(B) IN GENERAL.—

"(i) PROVISION OF CONFIDENTIAL INFORMATION.—When a subsection (k) applicant submits an application under subsection (k), such applicant shall provide to the persons described in clause (ii), subject

to the terms of this paragraph, confidential access to the information required to be produced pursuant to paragraph (2) and any other information that the subsection (k) applicant determines, in its sole discretion, to be appropriate (referred to in this subsection as the 'confidential information').

"(ii) RECIPIENTS OF INFORMATION.—The persons described in this clause are the following:

"(I) OUTSIDE COUNSEL.—One or more attorneys designated by the reference product sponsor who are employees of an entity other than the reference product sponsor (referred to in this paragraph as the 'outside counsel'), provided that such attorneys do not engage, formally or informally, in patent prosecution relevant or related to the reference product.

"(II) IN-HOUSE COUNSEL.—One attorney that represents the reference product sponsor who is an employee of the reference product sponsor, pro-

vided that such attorney does not engage, formally or informally, in patent prosecution relevant or related to the reference product.

"(iii) PATENT OWNER ACCESS.—A representative of the owner of a patent exclusively licensed to a reference product sponsor with respect to the reference product and who has retained a right to assert the patent or participate in litigation concerning the patent may be provided the confidential information, provided that the representative informs the reference product sponsor and the subsection (k) applicant of his or her agreement to be subject to the confidentiality provisions set forth in this paragraph, including those under clause (ii).

"(C) LIMITATION ON DISCLOSURE.—No person that receives confidential information pursuant to subparagraph (B) shall disclose any confidential information to any other person or entity, including the reference product sponsor employees, outside scientific consultants, or other outside counsel retained by the

reference product sponsor, without the prior written consent of the subsection (k) applicant, which shall not be unreasonably withheld.

"(D) USE OF CONFIDENTIAL INFORMATION.—Confidential information shall be used for the sole and exclusive purpose of determining, with respect to each patent assigned to or exclusively licensed by the reference product sponsor, whether a claim of patent infringement could reasonably be asserted if the subsection (k) applicant engaged in the manufacture, use, offering for sale, sale, or importation into the United States of the biological product that is the subject of the application under subsection (k).

"(E) OWNERSHIP OF CONFIDENTIAL INFORMATION.—The confidential information disclosed under this paragraph is, and shall remain, the property of the subsection (k) applicant. By providing the confidential information pursuant to this paragraph, the subsection (k) applicant does not provide the reference product sponsor or the outside counsel any interest in or license to use the confidential information, for

1 purposes other than those specified in subpara-
2 graph (D).

3 "(F) EFFECT OF INFRINGEMENT AC-
4 TION.—In the event that the reference product
5 sponsor files a patent infringement suit, the use
6 of confidential information shall continue to be
7 governed by the terms of this paragraph until
8 such time as a court enters a protective order
9 regarding the information. Upon entry of such
10 order, the subsection (k) applicant may redesig-
11 nate confidential information in accordance
12 with the terms of that order. No confidential in-
13 formation shall be included in any publicly-
14 available complaint or other pleading. In the
15 event that the reference product sponsor does
16 not file an infringement action by the date spec-
17 ified in paragraph (6), the reference product
18 sponsor shall return or destroy all confidential
19 information received under this paragraph, pro-
20 vided that if the reference product sponsor opts
21 to destroy such information, it will confirm de-
22 struction in writing to the subsection (k) appli-
23 cant.

24 "(G) RULE OF CONSTRUCTION.—Nothing
25 in this paragraph shall be construed—

"(i) as an admission by the subsection (k) applicant regarding the validity, enforceability, or infringement of any patent; or

"(ii) as an agreement or admission by the subsection (k) applicant with respect to the competency, relevance, or materiality of any confidential information.

"(H) EFFECT OF VIOLATION.—The disclosure of any confidential information in violation of this paragraph shall be deemed to cause the subsection (k) applicant to suffer irreparable harm for which there is no adequate legal remedy and the court shall consider immediate injunctive relief to be an appropriate and necessary remedy for any violation or threatened violation of this paragraph.

"(2) SUBSECTION (k) APPLICATION INFORMATION.—Not later than 20 days after the Secretary notifies the subsection (k) applicant that the application has been accepted for review, the subsection (k) applicant—

"(A) shall provide to the reference product sponsor a copy of the application submitted to the Secretary under subsection (k), and such

other information that describes the process or processes used to manufacture the biological product that is the subject of such application; and

"(B) may provide to the reference product sponsor additional information requested by or on behalf of the reference product sponsor.

"(3) LIST AND DESCRIPTION OF PATENTS.—

"(A) LIST BY REFERENCE PRODUCT SPONSOR.—Not later than 60 days after the receipt of the application and information under paragraph (2), the reference product sponsor shall provide to the subsection (k) applicant—

"(i) a list of patents for which the reference product sponsor believes a claim of patent infringement could reasonably be asserted by the reference product sponsor, or by a patent owner that has granted an exclusive license to the reference product sponsor with respect to the reference product, if a person not licensed by the reference product sponsor engaged in the making, using, offering to sell, selling, or importing into the United States of the bi-

ological product that is the subject of the subsection (k) application; and

"(ii) an identification of the patents on such list that the reference product sponsor would be prepared to license to the subsection (k) applicant.

"(B) LIST AND DESCRIPTION BY SUBSECTION (k) APPLICANT.—Not later than 60 days after receipt of the list under subparagraph (A), the subsection (k) applicant—

"(i) may provide to the reference product sponsor a list of patents to which the subsection (k) applicant believes a claim of patent infringement could reasonably be asserted by the reference product sponsor if a person not licensed by the reference product sponsor engaged in the making, using, offering to sell, selling, or importing into the United States of the biological product that is the subject of the subsection (k) application;

"(ii) shall provide to the reference product sponsor, with respect to each patent listed by the reference product sponsor

under subparagraph (A) or listed by the subsection (k) applicant under clause (i)—

"(I) a detailed statement that describes, on a claim by claim basis, the factual and legal basis of the opinion of the subsection (k) applicant that such patent is invalid, unenforceable, or will not be infringed by the commercial marketing of the biological product that is the subject of the subsection (k) application; or

"(II) a statement that the subsection (k) applicant does not intend to begin commercial marketing of the biological product before the date that such patent expires; and

"(iii) shall provide to the reference product sponsor a response regarding each patent identified by the reference product sponsor under subparagraph (A)(ii).

"(C) DESCRIPTION BY REFERENCE PRODUCT SPONSOR.—Not later than 60 days after receipt of the list and statement under subparagraph (B), the reference product sponsor shall provide to the subsection (k) applicant a de-

tailed statement that describes, with respect to each patent described in subparagraph (B)(ii)(I), on a claim by claim basis, the factual and legal basis of the opinion of the reference product sponsor that such patent will be infringed by the commercial marketing of the biological product that is the subject of the subsection (k) application and a response to the statement concerning validity and enforceability provided under subparagraph (B)(ii)(I).

"(4) PATENT RESOLUTION NEGOTIATIONS.—

"(A) IN GENERAL.—After receipt by the subsection (k) applicant of the statement under paragraph (3)(C), the reference product sponsor and the subsection (k) applicant shall engage in good faith negotiations to agree on which, if any, patents listed under paragraph (3) by the subsection (k) applicant or the reference product sponsor shall be the subject of an action for patent infringement under paragraph (6).

"(B) FAILURE TO REACH AGREEMENT.—If, within 15 days of beginning negotiations under subparagraph (A), the subsection (k) applicant and the reference product sponsor fail to

agree on a final and complete list of which, if any, patents listed under paragraph (3) by the subsection (k) applicant or the reference product sponsor shall be the subject of an action for patent infringement under paragraph (6), the provisions of paragraph (5) shall apply to the parties.

"(5) PATENT RESOLUTION IF NO AGREEMENT.—

"(A) NUMBER OF PATENTS.—The subsection (k) applicant shall notify the reference product sponsor of the number of patents that such applicant will provide to the reference product sponsor under subparagraph (B)(i)(I).

"(B) EXCHANGE OF PATENT LISTS.—

"(i) IN GENERAL.—On a date agreed to by the subsection (k) applicant and the reference product sponsor, but in no case later than 5 days after the subsection (k) applicant notifies the reference product sponsor under subparagraph (A), the subsection (k) applicant and the reference product sponsor shall simultaneously exchange—

"(I) the list of patents that the subsection (k) applicant believes should be the subject of an action for patent infringement under paragraph (6); and

"(II) the list of patents, in accordance with clause (ii), that the reference product sponsor believes should be the subject of an action for patent infringement under paragraph (6).

"(ii) NUMBER OF PATENTS LISTED BY REFERENCE PRODUCT SPONSOR.—

"(I) IN GENERAL.—Subject to subclause (II), the number of patents listed by the reference product sponsor under clause (i)(II) may not exceed the number of patents listed by the subsection (k) applicant under clause (i)(I).

"(II) EXCEPTION.—If a subsection (k) applicant does not list any patent under clause (i)(I), the reference product sponsor may list 1 patent under clause (i)(II).

"(6) IMMEDIATE PATENT INFRINGEMENT ACTION.—

"(A) ACTION IF AGREEMENT ON PATENT LIST.—If the subsection (k) applicant and the reference product sponsor agree on patents as described in paragraph (4), not later than 30 days after such agreement, the reference product sponsor shall bring an action for patent infringement with respect to each such patent.

"(B) ACTION IF NO AGREEMENT ON PATENT LIST.—If the provisions of paragraph (5) apply to the parties as described in paragraph (4)(B), not later than 30 days after the exchange of lists under paragraph (5)(B), the reference product sponsor shall bring an action for patent infringement with respect to each patent that is included on such lists.

"(C) NOTIFICATION AND PUBLICATION OF COMPLAINT.—

"(i) NOTIFICATION TO SECRETARY.—Not later than 30 days after a complaint is served to a subsection (k) applicant in an action for patent infringement described under this paragraph, the subsection (k)

applicant shall provide the Secretary with notice and a copy of such complaint.

"(ii) PUBLICATION BY SECRETARY.—The Secretary shall publish in the Federal Register notice of a complaint received under clause (i).

"(7) NEWLY ISSUED OR LICENSED PATENTS.—In the case of a patent that—

"(A) is issued to, or exclusively licensed by, the reference product sponsor after the date that the reference product sponsor provided the list to the subsection (k) applicant under paragraph (3)(A); and

"(B) the reference product sponsor reasonably believes that, due to the issuance of such patent, a claim of patent infringement could reasonably be asserted by the reference product sponsor if a person not licensed by the reference product sponsor engaged in the making, using, offering to sell, selling, or importing into the United States of the biological product that is the subject of the subsection (k) application,

not later than 30 days after such issuance or licensing, the reference product sponsor shall provide to the subsection (k) applicant a supplement to the list

provided by the reference product sponsor under paragraph (3)(A) that includes such patent, not later than 30 days after such supplement is provided, the subsection (k) applicant shall provide a statement to the reference product sponsor in accordance with paragraph (3)(B), and such patent shall be subject to paragraph (8).

"(8) NOTICE OF COMMERCIAL MARKETING AND PRELIMINARY INJUNCTION.—

"(A) NOTICE OF COMMERCIAL MARKETING.—The subsection (k) applicant shall provide notice to the reference product sponsor not later than 180 days before the date of the first commercial marketing of the biological product licensed under subsection (k).

"(B) PRELIMINARY INJUNCTION.—After receiving the notice under subparagraph (A) and before such date of the first commercial marketing of such biological product, the reference product sponsor may seek a preliminary injunction prohibiting the subsection (k) applicant from engaging in the commercial manufacture or sale of such biological product until the court decides the issue of patent validity, en-

forcement, and infringement with respect to any patent that is—

"(i) included in the list provided by the reference product sponsor under paragraph (3)(A) or in the list provided by the subsection (k) applicant under paragraph (3)(B); and

"(ii) not included, as applicable, on—

"(I) the list of patents described in paragraph (4); or

"(II) the lists of patents described in paragraph (5)(B).

"(C) REASONABLE COOPERATION.—If the reference product sponsor has sought a preliminary injunction under subparagraph (B), the reference product sponsor and the subsection (k) applicant shall reasonably cooperate to expedite such further discovery as is needed in connection with the preliminary injunction motion.

"(9) LIMITATION ON DECLARATORY JUDGMENT ACTION.—

"(A) SUBSECTION (k) APPLICATION PROVIDED.—If a subsection (k) applicant provides the application and information required under

paragraph (2)(A), neither the reference product sponsor nor the subsection (k) applicant may, prior to the date notice is received under paragraph (8)(A), bring any action under section 2201 of title 28, United States Code, for a declaration of infringement, validity, or enforceability of any patent that is described in clauses (i) and (ii) of paragraph (8)(B).

"(B) SUBSEQUENT FAILURE TO ACT BY SUBSECTION (k) APPLICANT.—If a subsection (k) applicant fails to complete an action required of the subsection (k) applicant under paragraph (3)(B)(ii), paragraph (5), paragraph (6)(C)(i), paragraph (7), or paragraph (8)(A), the reference product sponsor, but not the subsection (k) applicant, may bring an action under section 2201 of title 28, United States Code, for a declaration of infringement, validity, or enforceability of any patent included in the list described in paragraph (3)(A), including as provided under paragraph (7).

"(C) SUBSECTION (k) APPLICATION NOT PROVIDED.—If a subsection (k) applicant fails to provide the application and information required under paragraph (2)(A), the reference

product sponsor, but not the subsection (k) applicant, may bring an action under section 2201 of title 28, United States Code, for a declaration of infringement, validity, or enforceability of any patent that claims the biological product or a use of the biological product.''.

(b) DEFINITIONS.—Section 351(i) of the Public Health Service Act (42 U.S.C. 262(i)) is amended—

(1) by striking ''In this section, the term 'biological product' means'' and inserting the following: ''In this section:

''(1) The term 'biological product' means'';

(2) in paragraph (1), as so designated, by inserting ''protein (except any chemically synthesized polypeptide),'' after ''allergenic product,''; and

(3) by adding at the end the following:

''(2) The term 'biosimilar' or 'biosimilarity', in reference to a biological product that is the subject of an application under subsection (k), means—

''(A) that the biological product is highly similar to the reference product notwithstanding minor differences in clinically inactive components; and

''(B) there are no clinically meaningful differences between the biological product and the

reference product in terms of the safety, purity, and potency of the product.

"(3) The term 'interchangeable' or 'interchangeability', in reference to a biological product that is shown to meet the standards described in subsection (k)(4), means that the biological product may be substituted for the reference product without the intervention of the health care provider who prescribed the reference product.

"(4) The term 'reference product' means the single biological product licensed under subsection (a) against which a biological product is evaluated in an application submitted under subsection (k).".

(c) CONFORMING AMENDMENTS RELATING TO PATENTS.—

(1) PATENTS.—Section 271(e) of title 35, United States Code, is amended—

(A) in paragraph (2)—

(i) in subparagraph (A), by striking "or" at the end;

(ii) in subparagraph (B), by adding "or" at the end; and

(iii) by inserting after subparagraph (B) the following:

"(C)(i) with respect to a patent that is identified in the list of patents described in section 351(l)(3) of the Public Health Service Act (including as provided under section 351(l)(7) of such Act), an application seeking approval of a biological product, or

"(ii) if the applicant for the application fails to provide the application and information required under section 351(l)(2)(A) of such Act, an application seeking approval of a biological product for a patent that could be identified pursuant to section 351(l)(3)(A)(i) of such Act,"; and

(iv) in the matter following subparagraph (C) (as added by clause (iii)), by striking "or veterinary biological product" and inserting ", veterinary biological product, or biological product";

(B) in paragraph (4)—

(i) in subparagraph (B), by—

(I) striking "or veterinary biological product" and inserting ", veterinary biological product, or biological product"; and

(II) striking "and" at the end;

(ii) in subparagraph (C), by—

(I) striking ''or veterinary biological product'' and inserting '', veterinary biological product, or biological product''; and

(II) striking the period and inserting '', and'';

(iii) by inserting after subparagraph (C) the following:

''(D) the court shall order a permanent injunction prohibiting any infringement of the patent by the biological product involved in the infringement until a date which is not earlier than the date of the expiration of the patent that has been infringed under paragraph (2)(C), provided the patent is the subject of a final court decision, as defined in section 351(k)(6) of the Public Health Service Act, in an action for infringement of the patent under section 351(l)(6) of such Act, and the biological product has not yet been approved because of section 351(k)(7) of such Act.''; and

(iv) in the matter following subparagraph (D) (as added by clause (iii)), by striking ''and (C)'' and inserting ''(C), and (D)''; and

(C) by adding at the end the following:

"(6)(A) Subparagraph (B) applies, in lieu of paragraph (4), in the case of a patent—

"(i) that is identified, as applicable, in the list of patents described in section 351(l)(4) of the Public Health Service Act or the lists of patents described in section 351(l)(5)(B) of such Act with respect to a biological product; and

"(ii) for which an action for infringement of the patent with respect to the biological product—

"(I) was brought after the expiration of the 30-day period described in subparagraph (A) or (B), as applicable, of section 351(l)(6) of such Act; or

"(II) was brought before the expiration of the 30-day period described in subclause (I), but which was dismissed without prejudice or was not prosecuted to judgment in good faith.

"(B) In an action for infringement of a patent described in subparagraph (A), the sole and exclusive remedy that may be granted by a court, upon a finding that the making, using, offering to sell, selling, or importation into the United States of the biological product that is the subject of the action infringed the patent, shall be a reasonable royalty.

"(C) The owner of a patent that should have been included in the list described in section 351(l)(3)(A) of the Public Health Service Act, including as provided under section 351(l)(7) of such Act for a biological product, but was not timely included in such list, may not bring an action under this section for infringement of the patent with respect to the biological product.".

(2) CONFORMING AMENDMENT UNDER TITLE 28.—Section 2201(b) of title 28, United States Code, is amended by inserting before the period the following: ", or section 351 of the Public Health Service Act".

(d) CONFORMING AMENDMENTS UNDER THE FEDERAL FOOD, DRUG, AND COSMETIC ACT.—

(1) CONTENT AND REVIEW OF APPLICATIONS.—Section 505(b)(5)(B) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(b)(5)(B)) is amended by inserting before the period at the end of the first sentence the following: "or, with respect to an applicant for approval of a biological product under section 351(k) of the Public Health Service Act, any necessary clinical study or studies".

(2) NEW ACTIVE INGREDIENT.—Section 505B of the Federal Food, Drug, and Cosmetic Act (21

U.S.C. 355c) is amended by adding at the end the following:

"(n) NEW ACTIVE INGREDIENT.—

"(1) NON-INTERCHANGEABLE BIOSIMILAR BIOLOGICAL PRODUCT.—A biological product that is biosimilar to a reference product under section 351 of the Public Health Service Act, and that the Secretary has not determined to meet the standards described in subsection (k)(4) of such section for interchangeability with the reference product, shall be considered to have a new active ingredient under this section.

"(2) INTERCHANGEABLE BIOSIMILAR BIOLOGICAL PRODUCT.—A biological product that is interchangeable with a reference product under section 351 of the Public Health Service Act shall not be considered to have a new active ingredient under this section.".

(e) PRODUCTS PREVIOUSLY APPROVED UNDER SECTION 505.—

(1) REQUIREMENT TO FOLLOW SECTION 351.—Except as provided in paragraph (2), an application for a biological product shall be submitted under section 351 of the Public Health Service Act (42 U.S.C. 262) (as amended by this Act).

(2) EXCEPTION.—An application for a biological product may be submitted under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) if—

(A) such biological product is in a product class for which a biological product in such product class is the subject of an application approved under such section 505 not later than the date of enactment of this Act; and

(B) such application—

(i) has been submitted to the Secretary of Health and Human Services (referred to in this subtitle as the ''Secretary'') before the date of enactment of this Act; or

(ii) is submitted to the Secretary not later than the date that is 10 years after the date of enactment of this Act.

(3) LIMITATION.—Notwithstanding paragraph (2), an application for a biological product may not be submitted under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) if there is another biological product approved under subsection (a) of section 351 of the Public Health Service Act that could be a reference product with re-

1 spect to such application (within the meaning of
2 such section 351) if such application were submitted
3 under subsection (k) of such section 351.
4 (4) DEEMED APPROVED UNDER SECTION
5 351.—An approved application for a biological prod-
6 uct under section 505 of the Federal Food, Drug,
7 and Cosmetic Act (21 U.S.C. 355) shall be deemed
8 to be a license for the biological product under such
9 section 351 on the date that is 10 years after the
10 date of enactment of this Act.
11 (5) DEFINITIONS.—For purposes of this sub-
12 section, the term ''biological product'' has the mean-
13 ing given such term under section 351 of the Public
14 Health Service Act (42 U.S.C. 262) (as amended by
15 this Act).
16 (f) FOLLOW-ON BIOLOGICS USER FEES.—
17 (1) DEVELOPMENT OF USER FEES FOR BIO-
18 SIMILAR BIOLOGICAL PRODUCTS.—
19 (A) IN GENERAL.—Beginning not later
20 than October 1, 2010, the Secretary shall de-
21 velop recommendations to present to Congress
22 with respect to the goals, and plans for meeting
23 the goals, for the process for the review of bio-
24 similar biological product applications sub-
25 mitted under section 351(k) of the Public

Health Service Act (as added by this Act) for the first 5 fiscal years after fiscal year 2012. In developing such recommendations, the Secretary shall consult with—

(i) the Committee on Health, Education, Labor, and Pensions of the Senate;

(ii) the Committee on Energy and Commerce of the House of Representatives;

(iii) scientific and academic experts;

(iv) health care professionals;

(v) representatives of patient and consumer advocacy groups; and

(vi) the regulated industry.

(B) PUBLIC REVIEW OF RECOMMENDATIONS.—After negotiations with the regulated industry, the Secretary shall—

(i) present the recommendations developed under subparagraph (A) to the Congressional committees specified in such subparagraph;

(ii) publish such recommendations in the Federal Register;

(iii) provide for a period of 30 days for the public to provide written comments on such recommendations;

(iv) hold a meeting at which the public may present its views on such recommendations; and

(v) after consideration of such public views and comments, revise such recommendations as necessary.

(C) TRANSMITTAL OF RECOMMENDATIONS.—Not later than January 15, 2012, the Secretary shall transmit to Congress the revised recommendations under subparagraph (B), a summary of the views and comments received under such subparagraph, and any changes made to the recommendations in response to such views and comments.

(2) ESTABLISHMENT OF USER FEE PROGRAM.—It is the sense of the Senate that, based on the recommendations transmitted to Congress by the Secretary pursuant to paragraph (1)(C), Congress should authorize a program, effective on October 1, 2012, for the collection of user fees relating to the submission of biosimilar biological product applica-

1 tions under section 351(k) of the Public Health
2 Service Act (as added by this Act).
3 (3) TRANSITIONAL PROVISIONS FOR USER FEES
4 FOR BIOSIMILAR BIOLOGICAL PRODUCTS.—
5 (A) APPLICATION OF THE PRESCRIPTION
6 DRUG USER FEE PROVISIONS.—Section
7 735(1)(B) of the Federal Food, Drug, and Cos-
8 metic Act (21 U.S.C. 379g(1)(B)) is amended
9 by striking ''section 351'' and inserting ''sub-
10 section (a) or (k) of section 351''.
11 (B) EVALUATION OF COSTS OF REVIEWING
12 BIOSIMILAR BIOLOGICAL PRODUCT APPLICA-
13 TIONS.—During the period beginning on the
14 date of enactment of this Act and ending on
15 October 1, 2010, the Secretary shall collect and
16 evaluate data regarding the costs of reviewing
17 applications for biological products submitted
18 under section 351(k) of the Public Health Serv-
19 ice Act (as added by this Act) during such pe-
20 riod.
21 (C) AUDIT.—
22 (i) IN GENERAL.—On the date that is
23 2 years after first receiving a user fee ap-
24 plicable to an application for a biological
25 product under section 351(k) of the Public

1 Health Service Act (as added by this Act),
2 and on a biennial basis thereafter until Oc-
3 tober 1, 2013, the Secretary shall perform
4 an audit of the costs of reviewing such ap-
5 plications under such section 351(k). Such
6 an audit shall compare—
7 (I) the costs of reviewing such
8 applications under such section
9 351(k) to the amount of the user fee
10 applicable to such applications; and
11 (II)(aa) such ratio determined
12 under subclause (I); to
13 (bb) the ratio of the costs of re-
14 viewing applications for biological
15 products under section 351(a) of such
16 Act (as amended by this Act) to the
17 amount of the user fee applicable to
18 such applications under such section
19 351(a).
20 (ii) ALTERATION OF USER FEE.—If
21 the audit performed under clause (i) indi-
22 cates that the ratios compared under sub-
23 clause (II) of such clause differ by more
24 than 5 percent, then the Secretary shall
25 alter the user fee applicable to applications

1 submitted under such section 351(k) to
2 more appropriately account for the costs of
3 reviewing such applications.
4 (iii) ACCOUNTING STANDARDS.—The
5 Secretary shall perform an audit under
6 clause (i) in conformance with the account-
7 ing principles, standards, and requirements
8 prescribed by the Comptroller General of
9 the United States under section 3511 of
10 title 31, United State Code, to ensure the
11 validity of any potential variability.
12 (4) AUTHORIZATION OF APPROPRIATIONS.—
13 There is authorized to be appropriated to carry out
14 this subsection such sums as may be necessary for
15 each of fiscal years 2010 through 2012.
16 (g) PEDIATRIC STUDIES OF BIOLOGICAL PROD-
17 UCTS.—
18 (1) IN GENERAL.—Section 351 of the Public
19 Health Service Act (42 U.S.C. 262) is amended by
20 adding at the end the following:
21 ''(m) PEDIATRIC STUDIES.—
22 ''(1) APPLICATION OF CERTAIN PROVISIONS.—
23 The provisions of subsections (a), (d), (e), (f), (i),
24 (j), (k), (l), (p), and (q) of section 505A of the Fed-
25 eral Food, Drug, and Cosmetic Act shall apply with

respect to the extension of a period under paragraphs (2) and (3) to the same extent and in the same manner as such provisions apply with respect to the extension of a period under subsection (b) or (c) of section 505A of the Federal Food, Drug, and Cosmetic Act.

"(2) MARKET EXCLUSIVITY FOR NEW BIOLOGICAL PRODUCTS.—If, prior to approval of an application that is submitted under subsection (a), the Secretary determines that information relating to the use of a new biological product in the pediatric population may produce health benefits in that population, the Secretary makes a written request for pediatric studies (which shall include a timeframe for completing such studies), the applicant agrees to the request, such studies are completed using appropriate formulations for each age group for which the study is requested within any such timeframe, and the reports thereof are submitted and accepted in accordance with section 505A(d)(3) of the Federal Food, Drug, and Cosmetic Act—

"(A) the periods for such biological product referred to in subsection (k)(7) are deemed to be 4 years and 6 months rather than 4 years

and 12 years and 6 months rather than 12 years; and

"(B) if the biological product is designated under section 526 for a rare disease or condition, the period for such biological product referred to in section 527(a) is deemed to be 7 years and 6 months rather than 7 years.

"(3) MARKET EXCLUSIVITY FOR ALREADY-MARKETED BIOLOGICAL PRODUCTS.—If the Secretary determines that information relating to the use of a licensed biological product in the pediatric population may produce health benefits in that population and makes a written request to the holder of an approved application under subsection (a) for pediatric studies (which shall include a timeframe for completing such studies), the holder agrees to the request, such studies are completed using appropriate formulations for each age group for which the study is requested within any such timeframe, and the reports thereof are submitted and accepted in accordance with section 505A(d)(3) of the Federal Food, Drug, and Cosmetic Act—

"(A) the periods for such biological product referred to in subsection (k)(7) are deemed to be 4 years and 6 months rather than 4 years

and 12 years and 6 months rather than 12 years; and

"(B) if the biological product is designated under section 526 for a rare disease or condition, the period for such biological product referred to in section 527(a) is deemed to be 7 years and 6 months rather than 7 years.

"(4) EXCEPTION.—The Secretary shall not extend a period referred to in paragraph (2)(A), (2)(B), (3)(A), or (3)(B) if the determination under section 505A(d)(3) is made later than 9 months prior to the expiration of such period.".

(2) STUDIES REGARDING PEDIATRIC RESEARCH.—

(A) PROGRAM FOR PEDIATRIC STUDY OF DRUGS.—Subsection (a)(1) of section 409I of the Public Health Service Act (42 U.S.C. 284m) is amended by inserting ", biological products," after "including drugs".

(B) INSTITUTE OF MEDICINE STUDY.—Section 505A(p) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355b(p)) is amended by striking paragraphs (4) and (5) and inserting the following:

"(4) review and assess the number and importance of biological products for children that are being tested as a result of the amendments made by the Biologics Price Competition and Innovation Act of 2009 and the importance for children, health care providers, parents, and others of labeling changes made as a result of such testing;

"(5) review and assess the number, importance, and prioritization of any biological products that are not being tested for pediatric use; and

"(6) offer recommendations for ensuring pediatric testing of biological products, including consideration of any incentives, such as those provided under this section or section 351(m) of the Public Health Service Act.".

(h) ORPHAN PRODUCTS.—If a reference product, as defined in section 351 of the Public Health Service Act (42 U.S.C. 262) (as amended by this Act) has been designated under section 526 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bb) for a rare disease or condition, a biological product seeking approval for such disease or condition under subsection (k) of such section 351 as biosimilar to, or interchangeable with, such reference product may be licensed by the Secretary only after the expiration for such reference product of the later of—

(1) the 7-year period described in section 527(a) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360cc(a)); and

(2) the 12-year period described in subsection (k)(7) of such section 351.

SEC. 7003. SAVINGS.

(a) DETERMINATION.—The Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, shall for each fiscal year determine the amount of savings to the Federal Government as a result of the enactment of this subtitle.

(b) USE.—Notwithstanding any other provision of this subtitle (or an amendment made by this subtitle), the savings to the Federal Government generated as a result of the enactment of this subtitle shall be used for deficit reduction.

Subtitle B—More Affordable Medicines for Children and Underserved Communities

SEC. 7101. EXPANDED PARTICIPATION IN 340B PROGRAM.

(a) EXPANSION OF COVERED ENTITIES RECEIVING DISCOUNTED PRICES.—Section 340B(a)(4) of the Public Health Service Act (42 U.S.C. 256b(a)(4)) is amended by adding at the end the following:

"(M) A children's hospital excluded from the Medicare prospective payment system pursuant to section 1886(d)(1)(B)(iii) of the Social Security Act, or a free-standing cancer hospital excluded from the Medicare prospective payment system pursuant to section 1886(d)(1)(B)(v) of the Social Security Act, that would meet the requirements of subparagraph (L), including the disproportionate share adjustment percentage requirement under clause (ii) of such subparagraph, if the hospital were a subsection (d) hospital as defined by section 1886(d)(1)(B) of the Social Security Act.

"(N) An entity that is a critical access hospital (as determined under section 1820(c)(2) of the Social Security Act), and that meets the requirements of subparagraph (L)(i).

"(O) An entity that is a rural referral center, as defined by section 1886(d)(5)(C)(i) of the Social Security Act, or a sole community hospital, as defined by section 1886(d)(5)(C)(iii) of such Act, and that both meets the requirements of subparagraph (L)(i) and has a disproportionate share adjustment percentage equal to or greater than 8 percent.".

(b) EXTENSION OF DISCOUNT TO INPATIENT DRUGS.—Section 340B of the Public Health Service Act (42 U.S.C. 256b) is amended—

(1) in paragraphs (2), (5), (7), and (9) of subsection (a), by striking ''outpatient'' each place it appears; and

(2) in subsection (b)—

(A) by striking ''OTHER DEFINITION'' and all that follows through ''In this section'' and inserting the following: ''OTHER DEFINITIONS.—

''(1) IN GENERAL.—In this section''; and

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

''(2) COVERED DRUG.—In this section, the term 'covered drug'—

''(A) means a covered outpatient drug (as defined in section 1927(k)(2) of the Social Security Act); and

''(B) includes, notwithstanding paragraph (3)(A) of section 1927(k) of such Act, a drug used in connection with an inpatient or outpatient service provided by a hospital described in subparagraph (L), (M), (N), or (O) of sub-

1 section (a)(4) that is enrolled to participate in
2 the drug discount program under this section.''.
3 (c) PROHIBITION ON GROUP PURCHASING ARRANGE-
4 MENTS.—Section 340B(a) of the Public Health Service
5 Act (42 U.S.C. 256b(a)) is amended—
6 (1) in paragraph (4)(L)—
7 (A) in clause (i), by adding ''and'' at the
8 end;
9 (B) in clause (ii), by striking ''; and'' and
10 inserting a period; and
11 (C) by striking clause (iii); and
12 (2) in paragraph (5), as amended by subsection
13 (b)—
14 (A) by redesignating subparagraphs (C)
15 and (D) as subparagraphs (D) and (E); respec-
16 tively; and
17 (B) by inserting after subparagraph (B),
18 the following:
19 ''(C) PROHIBITION ON GROUP PURCHASING
20 ARRANGEMENTS.—
21 ''(i) IN GENERAL.—A hospital de-
22 scribed in subparagraph (L), (M), (N), or
23 (O) of paragraph (4) shall not obtain cov-
24 ered outpatient drugs through a group
25 purchasing organization or other group

1 purchasing arrangement, except as per-
2 mitted or provided for pursuant to clauses
3 (ii) or (iii).
4 "(ii) INPATIENT DRUGS.—Clause (i)
5 shall not apply to drugs purchased for in-
6 patient use.
7 "(iii) EXCEPTIONS.—The Secretary
8 shall establish reasonable exceptions to
9 clause (i)—
10 "(I) with respect to a covered
11 outpatient drug that is unavailable to
12 be purchased through the program
13 under this section due to a drug
14 shortage problem, manufacturer non-
15 compliance, or any other circumstance
16 beyond the hospital's control;
17 "(II) to facilitate generic substi-
18 tution when a generic covered out-
19 patient drug is available at a lower
20 price; or
21 "(III) to reduce in other ways
22 the administrative burdens of man-
23 aging both inventories of drugs sub-
24 ject to this section and inventories of
25 drugs that are not subject to this sec-

tion, so long as the exceptions do not create a duplicate discount problem in violation of subparagraph (A) or a diversion problem in violation of subparagraph (B).

"(iv) PURCHASING ARRANGEMENTS FOR INPATIENT DRUGS.—The Secretary shall ensure that a hospital described in subparagraph (L), (M), (N), or (O) of subsection (a)(4) that is enrolled to participate in the drug discount program under this section shall have multiple options for purchasing covered drugs for inpatients, including by utilizing a group purchasing organization or other group purchasing arrangement, establishing and utilizing its own group purchasing program, purchasing directly from a manufacturer, and any other purchasing arrangements that the Secretary determines is appropriate to ensure access to drug discount pricing under this section for inpatient drugs taking into account the particular needs of small and rural hospitals.".

(d) MEDICAID CREDITS ON INPATIENT DRUGS.—Section 340B of the Public Health Service Act (42 U.S.C. 256b) is amended by striking subsection (c) and inserting the following:

"(c) MEDICAID CREDIT.—Not later than 90 days after the date of filing of the hospital's most recently filed Medicare cost report, the hospital shall issue a credit as determined by the Secretary to the State Medicaid program for inpatient covered drugs provided to Medicaid recipients.".

(e) EFFECTIVE DATES.—

(1) IN GENERAL.—The amendments made by this section and section 7102 shall take effect on January 1, 2010, and shall apply to drugs purchased on or after January 1, 2010.

(2) EFFECTIVENESS.—The amendments made by this section and section 7102 shall be effective and shall be taken into account in determining whether a manufacturer is deemed to meet the requirements of section 340B(a) of the Public Health Service Act (42 U.S.C. 256b(a)), notwithstanding any other provision of law.

SEC. 7102. IMPROVEMENTS TO 340B PROGRAM INTEGRITY.

(a) INTEGRITY IMPROVEMENTS.—Subsection (d) of section 340B of the Public Health Service Act (42 U.S.C. 256b) is amended to read as follows:

"(d) IMPROVEMENTS IN PROGRAM INTEGRITY.—

"(1) MANUFACTURER COMPLIANCE.—

"(A) IN GENERAL.—From amounts appropriated under paragraph (4), the Secretary shall provide for improvements in compliance by manufacturers with the requirements of this section in order to prevent overcharges and other violations of the discounted pricing requirements specified in this section.

"(B) IMPROVEMENTS.—The improvements described in subparagraph (A) shall include the following:

"(i) The development of a system to enable the Secretary to verify the accuracy of ceiling prices calculated by manufacturers under subsection (a)(1) and charged to covered entities, which shall include the following:

"(I) Developing and publishing through an appropriate policy or regulatory issuance, precisely defined standards and methodology for the

calculation of ceiling prices under such subsection.

"(II) Comparing regularly the ceiling prices calculated by the Secretary with the quarterly pricing data that is reported by manufacturers to the Secretary.

"(III) Performing spot checks of sales transactions by covered entities.

"(IV) Inquiring into the cause of any pricing discrepancies that may be identified and either taking, or requiring manufacturers to take, such corrective action as is appropriate in response to such price discrepancies.

"(ii) The establishment of procedures for manufacturers to issue refunds to covered entities in the event that there is an overcharge by the manufacturers, including the following:

"(I) Providing the Secretary with an explanation of why and how the overcharge occurred, how the refunds will be calculated, and to whom the refunds will be issued.

1 "(II) Oversight by the Secretary
2 to ensure that the refunds are issued
3 accurately and within a reasonable pe-
4 riod of time, both in routine instances
5 of retroactive adjustment to relevant
6 pricing data and exceptional cir-
7 cumstances such as erroneous or in-
8 tentional overcharging for covered
9 drugs.
10 "(iii) The provision of access through
11 the Internet website of the Department of
12 Health and Human Services to the applica-
13 ble ceiling prices for covered drugs as cal-
14 culated and verified by the Secretary in ac-
15 cordance with this section, in a manner
16 (such as through the use of password pro-
17 tection) that limits such access to covered
18 entities and adequately assures security
19 and protection of privileged pricing data
20 from unauthorized re-disclosure.
21 "(iv) The development of a mecha-
22 nism by which—
23 "(I) rebates and other discounts
24 provided by manufacturers to other
25 purchasers subsequent to the sale of

1 covered drugs to covered entities are
2 reported to the Secretary; and
3 ''(II) appropriate credits and re-
4 funds are issued to covered entities if
5 such discounts or rebates have the ef-
6 fect of lowering the applicable ceiling
7 price for the relevant quarter for the
8 drugs involved.
9 ''(v) Selective auditing of manufactur-
10 ers and wholesalers to ensure the integrity
11 of the drug discount program under this
12 section.
13 ''(vi) The imposition of sanctions in
14 the form of civil monetary penalties,
15 which—
16 ''(I) shall be assessed according
17 to standards established in regulations
18 to be promulgated by the Secretary
19 not later than 180 days after the date
20 of enactment of the Patient Protec-
21 tion and Affordable Care Act;
22 ''(II) shall not exceed $5,000 for
23 each instance of overcharging a cov-
24 ered entity that may have occurred;
25 and

"(III) shall apply to any manufacturer with an agreement under this section that knowingly and intentionally charges a covered entity a price for purchase of a drug that exceeds the maximum applicable price under subsection (a)(1).

"(2) COVERED ENTITY COMPLIANCE.—

"(A) IN GENERAL.—From amounts appropriated under paragraph (4), the Secretary shall provide for improvements in compliance by covered entities with the requirements of this section in order to prevent diversion and violations of the duplicate discount provision and other requirements specified under subsection (a)(5).

"(B) IMPROVEMENTS.—The improvements described in subparagraph (A) shall include the following:

"(i) The development of procedures to enable and require covered entities to regularly update (at least annually) the information on the Internet website of the Department of Health and Human Services relating to this section.

"(ii) The development of a system for the Secretary to verify the accuracy of information regarding covered entities that is listed on the website described in clause (i).

"(iii) The development of more detailed guidance describing methodologies and options available to covered entities for billing covered drugs to State Medicaid agencies in a manner that avoids duplicate discounts pursuant to subsection (a)(5)(A).

"(iv) The establishment of a single, universal, and standardized identification system by which each covered entity site can be identified by manufacturers, distributors, covered entities, and the Secretary for purposes of facilitating the ordering, purchasing, and delivery of covered drugs under this section, including the processing of chargebacks for such drugs.

"(v) The imposition of sanctions, in appropriate cases as determined by the Secretary, additional to those to which covered entities are subject under subsection

(a)(5)(E), through one or more of the following actions:

"(I) Where a covered entity knowingly and intentionally violates subsection (a)(5)(B), the covered entity shall be required to pay a monetary penalty to a manufacturer or manufacturers in the form of interest on sums for which the covered entity is found liable under subsection (a)(5)(E), such interest to be compounded monthly and equal to the current short term interest rate as determined by the Federal Reserve for the time period for which the covered entity is liable.

"(II) Where the Secretary determines a violation of subsection (a)(5)(B) was systematic and egregious as well as knowing and intentional, removing the covered entity from the drug discount program under this section and disqualifying the entity from re-entry into such pro-

gram for a reasonable period of time to be determined by the Secretary.

"(III) Referring matters to appropriate Federal authorities within the Food and Drug Administration, the Office of Inspector General of Department of Health and Human Services, or other Federal agencies for consideration of appropriate action under other Federal statutes, such as the Prescription Drug Marketing Act (21 U.S.C. 353).

"(3) ADMINISTRATIVE DISPUTE RESOLUTION PROCESS.—

"(A) IN GENERAL.—Not later than 180 days after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary shall promulgate regulations to establish and implement an administrative process for the resolution of claims by covered entities that they have been overcharged for drugs purchased under this section, and claims by manufacturers, after the conduct of audits as authorized by subsection (a)(5)(D), of violations of subsections (a)(5)(A) or (a)(5)(B), including ap-

propriate procedures for the provision of remedies and enforcement of determinations made pursuant to such process through mechanisms and sanctions described in paragraphs (1)(B) and (2)(B).

"(B) DEADLINES AND PROCEDURES.—Regulations promulgated by the Secretary under subparagraph (A) shall—

"(i) designate or establish a decision-making official or decision-making body within the Department of Health and Human Services to be responsible for reviewing and finally resolving claims by covered entities that they have been charged prices for covered drugs in excess of the ceiling price described in subsection (a)(1), and claims by manufacturers that violations of subsection (a)(5)(A) or (a)(5)(B) have occurred;

"(ii) establish such deadlines and procedures as may be necessary to ensure that claims shall be resolved fairly, efficiently, and expeditiously;

"(iii) establish procedures by which a covered entity may discover and obtain

1 such information and documents from
2 manufacturers and third parties as may be
3 relevant to demonstrate the merits of a
4 claim that charges for a manufacturer's
5 product have exceeded the applicable ceil-
6 ing price under this section, and may sub-
7 mit such documents and information to the
8 administrative official or body responsible
9 for adjudicating such claim;
10 ''(iv) require that a manufacturer con-
11 duct an audit of a covered entity pursuant
12 to subsection (a)(5)(D) as a prerequisite to
13 initiating administrative dispute resolution
14 proceedings against a covered entity;
15 ''(v) permit the official or body des-
16 ignated under clause (i), at the request of
17 a manufacturer or manufacturers, to con-
18 solidate claims brought by more than one
19 manufacturer against the same covered en-
20 tity where, in the judgment of such official
21 or body, consolidation is appropriate and
22 consistent with the goals of fairness and
23 economy of resources; and
24 ''(vi) include provisions and proce-
25 dures to permit multiple covered entities to

jointly assert claims of overcharges by the same manufacturer for the same drug or drugs in one administrative proceeding, and permit such claims to be asserted on behalf of covered entities by associations or organizations representing the interests of such covered entities and of which the covered entities are members.

"(C) FINALITY OF ADMINISTRATIVE RESOLUTION.—The administrative resolution of a claim or claims under the regulations promulgated under subparagraph (A) shall be a final agency decision and shall be binding upon the parties involved, unless invalidated by an order of a court of competent jurisdiction.

"(4) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection, such sums as may be necessary for fiscal year 2010 and each succeeding fiscal year.".

(b) CONFORMING AMENDMENTS.—Section 340B(a) of the Public Health Service Act (42 U.S.C. 256b(a)) is amended—

(1) in subsection (a)(1), by adding at the end the following: "Each such agreement shall require that the manufacturer furnish the Secretary with re-

ports, on a quarterly basis, of the price for each covered drug subject to the agreement that, according to the manufacturer, represents the maximum price that covered entities may permissibly be required to pay for the drug (referred to in this section as the 'ceiling price'), and shall require that the manufacturer offer each covered entity covered drugs for purchase at or below the applicable ceiling price if such drug is made available to any other purchaser at any price.''; and

(2) in the first sentence of subsection (a)(5)(E), as redesignated by section 7101(c), by inserting ''after audit as described in subparagraph (D) and'' after ''finds,''.

SEC. 7103. GAO STUDY TO MAKE RECOMMENDATIONS ON IMPROVING THE 340B PROGRAM.

(a) REPORT.—Not later than 18 months after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report that examines whether those individuals served by the covered entities under the program under section 340B of the Public Health Service Act (42 U.S.C. 256b) (referred to in this section as the ''340B program'') are receiving optimal health care services.

(b) RECOMMENDATIONS.—The report under subsection (a) shall include recommendations on the following:

(1) Whether the 340B program should be expanded since it is anticipated that the 47,000,000 individuals who are uninsured as of the date of enactment of this Act will have health care coverage once this Act is implemented.

(2) Whether mandatory sales of certain products by the 340B program could hinder patients access to those therapies through any provider.

(3) Whether income from the 340B program is being used by the covered entities under the program to further the program objectives.

TITLE VIII—CLASS ACT

SEC. 8001. SHORT TITLE OF TITLE.

This title may be cited as the ''Community Living Assistance Services and Supports Act'' or the ''CLASS Act''.

SEC. 8002. ESTABLISHMENT OF NATIONAL VOLUNTARY INSURANCE PROGRAM FOR PURCHASING COMMUNITY LIVING ASSISTANCE SERVICES AND SUPPORT.

(a) ESTABLISHMENT OF CLASS PROGRAM.—

(1) IN GENERAL.—The Public Health Service Act (42 U.S.C. 201 et seq.), as amended by section 4302(a), is amended by adding at the end the following:

"TITLE XXXII—COMMUNITY LIVING ASSISTANCE SERVICES AND SUPPORTS

"SEC. 3201. PURPOSE.

''The purpose of this title is to establish a national voluntary insurance program for purchasing community living assistance services and supports in order to—

''(1) provide individuals with functional limitations with tools that will allow them to maintain their personal and financial independence and live in the community through a new financing strategy for community living assistance services and supports;

''(2) establish an infrastructure that will help address the Nation's community living assistance services and supports needs;

''(3) alleviate burdens on family caregivers; and

''(4) address institutional bias by providing a financing mechanism that supports personal choice and independence to live in the community.

"SEC. 3202. DEFINITIONS.

''In this title:

1 "(1) ACTIVE ENROLLEE.—The term 'active en-
2 rollee' means an individual who is enrolled in the
3 CLASS program in accordance with section 3204
4 and who has paid any premiums due to maintain
5 such enrollment.

6 "(2) ACTIVELY EMPLOYED.—The term 'actively
7 employed' means an individual who—

8 "(A) is reporting for work at the individ-
9 ual's usual place of employment or at another
10 location to which the individual is required to
11 travel because of the individual's employment
12 (or in the case of an individual who is a mem-
13 ber of the uniformed services, is on active duty
14 and is physically able to perform the duties of
15 the individual's position); and

16 "(B) is able to perform all the usual and
17 customary duties of the individual's employment
18 on the individual's regular work schedule.

19 "(3) ACTIVITIES OF DAILY LIVING.—The term
20 'activities of daily living' means each of the following
21 activities specified in section 7702B(c)(2)(B) of the
22 Internal Revenue Code of 1986:

23 "(A) Eating.

24 "(B) Toileting.

25 "(C) Transferring.

"(D) Bathing.

"(E) Dressing.

"(F) Continence.

"(4) CLASS PROGRAM.—The term 'CLASS program' means the program established under this title.

"(5) ELIGIBILITY ASSESSMENT SYSTEM.—The term 'Eligibility Assessment System' means the entity established by the Secretary under section 3205(a)(2) to make functional eligibility determinations for the CLASS program.

"(6) ELIGIBLE BENEFICIARY.—

"(A) IN GENERAL.—The term 'eligible beneficiary' means any individual who is an active enrollee in the CLASS program and, as of the date described in subparagraph (B)—

"(i) has paid premiums for enrollment in such program for at least 60 months;

"(ii) has earned, with respect to at least 3 calendar years that occur during the first 60 months for which the individual has paid premiums for enrollment in the program, at least an amount equal to the amount of wages and self-employment income which an individual must have in

order to be credited with a quarter of coverage under section 213(d) of the Social Security Act for the year; and

"(iii) has paid premiums for enrollment in such program for at least 24 consecutive months, if a lapse in premium payments of more than 3 months has occurred during the period that begins on the date of the individual's enrollment and ends on the date of such determination.

"(B) DATE DESCRIBED.—For purposes of subparagraph (A), the date described in this subparagraph is the date on which the individual is determined to have a functional limitation described in section 3203(a)(1)(C) that is expected to last for a continuous period of more than 90 days.

"(C) REGULATIONS.—The Secretary shall promulgate regulations specifying exceptions to the minimum earnings requirements under subparagraph (A)(ii) for purposes of being considered an eligible beneficiary for certain populations.

"(7) HOSPITAL; NURSING FACILITY; INTERMEDIATE CARE FACILITY FOR THE MENTALLY RE-

1 TARDED; INSTITUTION FOR MENTAL DISEASES.—
2 The terms 'hospital', 'nursing facility', 'intermediate
3 care facility for the mentally retarded', and 'institu-
4 tion for mental diseases' have the meanings given
5 such terms for purposes of Medicaid.

6 "(8) CLASS INDEPENDENCE ADVISORY COUN-
7 CIL.—The term 'CLASS Independence Advisory
8 Council' or 'Council' means the Advisory Council es-
9 tablished under section 3207 to advise the Secretary.

10 "(9) CLASS INDEPENDENCE BENEFIT PLAN.—
11 The term 'CLASS Independence Benefit Plan'
12 means the benefit plan developed and designated by
13 the Secretary in accordance with section 3203.

14 "(10) CLASS INDEPENDENCE FUND.—The
15 term 'CLASS Independence Fund' or 'Fund' means
16 the fund established under section 3206.

17 "(11) MEDICAID.—The term 'Medicaid' means
18 the program established under title XIX of the So-
19 cial Security Act (42 U.S.C. 1396 et seq.).

20 "(12) POVERTY LINE.—The term 'poverty line'
21 has the meaning given that term in section
22 2110(c)(5) of the Social Security Act (42 U.S.C.
23 1397jj(c)(5)).

24 "(13) PROTECTION AND ADVOCACY SYSTEM.—
25 The term 'Protection and Advocacy System' means

the system for each State established under section 143 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15043).

"SEC. 3203. CLASS INDEPENDENCE BENEFIT PLAN.

"(a) PROCESS FOR DEVELOPMENT.—

"(1) IN GENERAL.—The Secretary, in consultation with appropriate actuaries and other experts, shall develop at least 3 actuarially sound benefit plans as alternatives for consideration for designation by the Secretary as the CLASS Independence Benefit Plan under which eligible beneficiaries shall receive benefits under this title. Each of the plan alternatives developed shall be designed to provide eligible beneficiaries with the benefits described in section 3205 consistent with the following requirements:

"(A) PREMIUMS.—

"(i) IN GENERAL.—Beginning with the first year of the CLASS program, and for each year thereafter, subject to clauses (ii) and (iii), the Secretary shall establish all premiums to be paid by enrollees for the year based on an actuarial analysis of the 75-year costs of the program that en-

1 sures solvency throughout such 75-year pe-
2 riod.
3 "(ii) NOMINAL PREMIUM FOR POOR-
4 EST INDIVIDUALS AND FULL-TIME STU-
5 DENTS.—
6 "(I) IN GENERAL.—The monthly
7 premium for enrollment in the
8 CLASS program shall not exceed the
9 applicable dollar amount per month
10 determined under subclause (II) for—
11 "(aa) any individual whose
12 income does not exceed the pov-
13 erty line; and
14 "(bb) any individual who
15 has not attained age 22, and is
16 actively employed during any pe-
17 riod in which the individual is a
18 full-time student (as determined
19 by the Secretary).
20 "(II) APPLICABLE DOLLAR
21 AMOUNT.—The applicable dollar
22 amount described in this subclause is
23 the amount equal to $5, increased by
24 the percentage increase in the con-
25 sumer price index for all urban con-

1 sumers (U.S. city average) for each
2 year occurring after 2009 and before
3 such year.
4 "(iii) CLASS INDEPENDENCE FUND
5 RESERVES.—At such time as the CLASS
6 program has been in operation for 10
7 years, the Secretary shall establish all pre-
8 miums to be paid by enrollees for the year
9 based on an actuarial analysis that accu-
10 mulated reserves in the CLASS Independ-
11 ence Fund would not decrease in that year.
12 At such time as the Secretary determines
13 the CLASS program demonstrates a sus-
14 tained ability to finance expected yearly ex-
15 penses with expected yearly premiums and
16 interest credited to the CLASS Independ-
17 ence Fund, the Secretary may decrease the
18 required amount of CLASS Independence
19 Fund reserves.
20 "(B) VESTING PERIOD.—A 5-year vesting
21 period for eligibility for benefits.
22 "(C) BENEFIT TRIGGERS.—A benefit trig-
23 ger for provision of benefits that requires a de-
24 termination that an individual has a functional
25 limitation, as certified by a licensed health care

practitioner, described in any of the following clauses that is expected to last for a continuous period of more than 90 days:

"(i) The individual is determined to be unable to perform at least the minimum number (which may be 2 or 3) of activities of daily living as are required under the plan for the provision of benefits without substantial assistance (as defined by the Secretary) from another individual.

"(ii) The individual requires substantial supervision to protect the individual from threats to health and safety due to substantial cognitive impairment.

"(iii) The individual has a level of functional limitation similar (as determined under regulations prescribed by the Secretary) to the level of functional limitation described in clause (i) or (ii).

"(D) CASH BENEFIT.—Payment of a cash benefit that satisfies the following requirements:

"(i) MINIMUM REQUIRED AMOUNT.—The benefit amount provides an eligible beneficiary with not less than an average of $50 per day (as determined based on

1 the reasonably expected distribution of
2 beneficiaries receiving benefits at various
3 benefit levels).
4 "(ii) AMOUNT SCALED TO FUNC-
5 TIONAL ABILITY.—The benefit amount is
6 varied based on a scale of functional abil-
7 ity, with not less than 2, and not more
8 than 6, benefit level amounts.
9 "(iii) DAILY OR WEEKLY.—The ben-
10 efit is paid on a daily or weekly basis.
11 "(iv) NO LIFETIME OR AGGREGATE
12 LIMIT.—The benefit is not subject to any
13 lifetime or aggregate limit.
14 "(E) COORDINATION WITH SUPPLE-
15 MENTAL COVERAGE OBTAINED THROUGH THE
16 EXCHANGE.—The benefits allow for coordina-
17 tion with any supplemental coverage purchased
18 through an Exchange established under section
19 1311 of the Patient Protection and Affordable
20 Care Act.
21 "(2) REVIEW AND RECOMMENDATION BY THE
22 CLASS INDEPENDENCE ADVISORY COUNCIL.—The
23 CLASS Independence Advisory Council shall—
24 "(A) evaluate the alternative benefit plans
25 developed under paragraph (1); and

"(B) recommend for designation as the CLASS Independence Benefit Plan for offering to the public the plan that the Council determines best balances price and benefits to meet enrollees' needs in an actuarially sound manner, while optimizing the probability of the long-term sustainability of the CLASS program.

"(3) DESIGNATION BY THE SECRETARY.—Not later than October 1, 2012, the Secretary, taking into consideration the recommendation of the CLASS Independence Advisory Council under paragraph (2)(B), shall designate a benefit plan as the CLASS Independence Benefit Plan. The Secretary shall publish such designation, along with details of the plan and the reasons for the selection by the Secretary, in a final rule that allows for a period of public comment.

"(b) ADDITIONAL PREMIUM REQUIREMENTS.—

"(1) ADJUSTMENT OF PREMIUMS.—

"(A) IN GENERAL.—Except as provided in subparagraphs (B), (C), (D), and (E), the amount of the monthly premium determined for an individual upon such individual's enrollment in the CLASS program shall remain the same

for as long as the individual is an active enrollee in the program.

"(B) RECALCULATED PREMIUM IF REQUIRED FOR PROGRAM SOLVENCY.—

"(i) IN GENERAL.—Subject to clause (ii), if the Secretary determines, based on the most recent report of the Board of Trustees of the CLASS Independence Fund, the advice of the CLASS Independence Advisory Council, and the annual report of the Inspector General of the Department of Health and Human Services, and waste, fraud, and abuse, or such other information as the Secretary determines appropriate, that the monthly premiums and income to the CLASS Independence Fund for a year are projected to be insufficient with respect to the 20-year period that begins with that year, the Secretary shall adjust the monthly premiums for individuals enrolled in the CLASS program as necessary (but maintaining a nominal premium for enrollees whose income is below the poverty line or who are full-time students actively employed).

"(ii) EXEMPTION FROM INCREASE.—Any increase in a monthly premium imposed as result of a determination described in clause (i) shall not apply with respect to the monthly premium of any active enrollee who—

"(I) has attained age 65;

"(II) has paid premiums for enrollment in the program for at least 20 years; and

"(III) is not actively employed.

"(C) RECALCULATED PREMIUM IF REENROLLMENT AFTER MORE THAN A 3-MONTH LAPSE.—

"(i) IN GENERAL.—The reenrollment of an individual after a 90-day period during which the individual failed to pay the monthly premium required to maintain the individual's enrollment in the CLASS program shall be treated as an initial enrollment for purposes of age-adjusting the premium for enrollment in the program.

"(ii) CREDIT FOR PRIOR MONTHS IF REENROLLED WITHIN 5 YEARS.—An individual who reenrolls in the CLASS pro-

gram after such a 90-day period and before the end of the 5-year period that begins with the first month for which the individual failed to pay the monthly premium required to maintain the individual's enrollment in the program shall be—

"(I) credited with any months of paid premiums that accrued prior to the individual's lapse in enrollment; and

"(II) notwithstanding the total amount of any such credited months, required to satisfy section 3202(6)(A)(ii) before being eligible to receive benefits.

"(D) NO LONGER STATUS AS A FULL-TIME STUDENT.—An individual subject to a nominal premium on the basis of being described in subsection (a)(1)(A)(ii)(I)(bb) who ceases to be described in that subsection, beginning with the first month following the month in which the individual ceases to be so described, shall be subject to the same monthly premium as the monthly premium that applies to an individual of the same age who first enrolls in the pro-

gram under the most similar circumstances as the individual (such as the first year of eligibility for enrollment in the program or in a subsequent year).

"(E) PENALTY FOR REENOLLMENT AFTER 5-YEAR LAPSE.—In the case of an individual who reenrolls in the CLASS program after the end of the 5-year period described in subparagraph (C)(ii), the monthly premium required for the individual shall be the age-adjusted premium that would be applicable to an initially enrolling individual who is the same age as the reenrolling individual, increased by the greater of—

"(i) an amount that the Secretary determines is actuarially sound for each month that occurs during the period that begins with the first month for which the individual failed to pay the monthly premium required to maintain the individual's enrollment in the CLASS program and ends with the month preceding the month in which the reenollment is effective; or

"(ii) 1 percent of the applicable age-adjusted premium for each such month occurring in such period.

"(2) ADMINISTRATIVE EXPENSES.—In determining the monthly premiums for the CLASS program the Secretary may factor in costs for administering the program, not to exceed for any year in which the program is in effect under this title, an amount equal to 3 percent of all premiums paid during the year.

"(3) NO UNDERWRITING REQUIREMENTS.—No underwriting (other than on the basis of age in accordance with subparagraphs (D) and (E) of paragraph (1)) shall be used to—

"(A) determine the monthly premium for enrollment in the CLASS program; or

"(B) prevent an individual from enrolling in the program.

"(c) SELF-ATTESTATION AND VERIFICATION OF INCOME.—The Secretary shall establish procedures to—

"(1) permit an individual who is eligible for the nominal premium required under subsection (a)(1)(A)(ii), as part of their automatic enrollment in the CLASS program, to self-attest that their income does not exceed the poverty line or that their

status as a full-time student who is actively employed;

"(2) verify, using procedures similar to the procedures used by the Commissioner of Social Security under section 1631(e)(1)(B)(ii) of the Social Security Act and consistent with the requirements applicable to the conveyance of data and information under section 1942 of such Act, the validity of such self-attestation; and

"(3) require an individual to confirm, on at least an annual basis, that their income does not exceed the poverty line or that they continue to maintain such status.

"SEC. 3204. ENROLLMENT AND DISENROLLMENT REQUIREMENTS.

"(a) AUTOMATIC ENROLLMENT.—

"(1) IN GENERAL.—Subject to paragraph (2), the Secretary, in coordination with the Secretary of the Treasury, shall establish procedures under which each individual described in subsection (c) may be automatically enrolled in the CLASS program by an employer of such individual in the same manner as an employer may elect to automatically enroll employees in a plan under section 401(k), 403(b), or 457 of the Internal Revenue Code of 1986.

1 "(2) ALTERNATIVE ENROLLMENT PROCE-
2 DURES.—The procedures established under para-
3 graph (1) shall provide for an alternative enrollment
4 process for an individual described in subsection (c)
5 in the case of such an individual—
6 "(A) who is self-employed;
7 "(B) who has more than 1 employer; or
8 "(C) whose employer does not elect to par-
9 ticipate in the automatic enrollment process es-
10 tablished by the Secretary.
11 "(3) ADMINISTRATION.—
12 "(A) IN GENERAL.—The Secretary and the
13 Secretary of the Treasury shall, by regulation,
14 establish procedures to ensure that an indi-
15 vidual is not automatically enrolled in the
16 CLASS program by more than 1 employer.
17 "(B) FORM.—Enrollment in the CLASS
18 program shall be made in such manner as the
19 Secretary may prescribe in order to ensure ease
20 of administration.
21 "(b) ELECTION TO OPT-OUT.—An individual de-
22 scribed in subsection (c) may elect to waive enrollment in
23 the CLASS program at any time in such form and manner
24 as the Secretary and the Secretary of the Treasury shall
25 prescribe.

1 "(c) INDIVIDUAL DESCRIBED.—For purposes of en-
2 rolling in the CLASS program, an individual described in
3 this paragraph is an individual—
4 "(1) who has attained age 18;
5 "(2) who—
6 "(A) receives wages on which there is im-
7 posed a tax under section 3201(a) of the Inter-
8 nal Revenue Code of 1986; or
9 "(B) derives self-employment income on
10 which there is imposed a tax under section
11 1401(a) of the Internal Revenue Code of 1986;
12 "(3) who is actively employed; and
13 "(4) who is not—
14 "(A) a patient in a hospital or nursing fa-
15 cility, an intermediate care facility for the men-
16 tally retarded, or an institution for mental dis-
17 eases and receiving medical assistance under
18 Medicaid; or
19 "(B) confined in a jail, prison, other penal
20 institution or correctional facility, or by court
21 order pursuant to conviction of a criminal of-
22 fense or in connection with a verdict or finding
23 described in section 202(x)(1)(A)(ii) of the So-
24 cial Security Act (42 U.S.C. 402(x)(1)(A)(ii)).

"(d) RULE OF CONSTRUCTION.—Nothing in this title shall be construed as requiring an active enrollee to continue to satisfy subparagraph (B) or (C) of subsection (c)(1) in order to maintain enrollment in the CLASS program.

"(e) PAYMENT.—

"(1) PAYROLL DEDUCTION.—An amount equal to the monthly premium for the enrollment in the CLASS program of an individual shall be deducted from the wages or self-employment income of such individual in accordance with such procedures as the Secretary, in coordination with the Secretary of the Treasury, shall establish for employers who elect to deduct and withhold such premiums on behalf of enrolled employees.

"(2) ALTERNATIVE PAYMENT MECHANISM.—The Secretary, in coordination with the Secretary of the Treasury, shall establish alternative procedures for the payment of monthly premiums by an individual enrolled in the CLASS program—

"(A) who does not have an employer who elects to deduct and withhold premiums in accordance with subparagraph (A); or

"(B) who does not earn wages or derive self-employment income.

1 "(f) TRANSFER OF PREMIUMS COLLECTED.—

2 "(1) IN GENERAL.—During each calendar year
3 the Secretary of the Treasury shall deposit into the
4 CLASS Independence Fund a total amount equal, in
5 the aggregate, to 100 percent of the premiums col-
6 lected during that year.

7 "(2) TRANSFERS BASED ON ESTIMATES.—The
8 amount deposited pursuant to paragraph (1) shall be
9 transferred in at least monthly payments to the
10 CLASS Independence Fund on the basis of esti-
11 mates by the Secretary and certified to the Sec-
12 retary of the Treasury of the amounts collected in
13 accordance with subparagraphs (A) and (B) of para-
14 graph (5). Proper adjustments shall be made in
15 amounts subsequently transferred to the Fund to
16 the extent prior estimates were in excess of, or were
17 less than, actual amounts collected.

18 "(g) OTHER ENROLLMENT AND DISENROLLMENT
19 OPPORTUNITIES.—The Secretary, in coordination with
20 the Secretary of the Treasury, shall establish procedures
21 under which—

22 "(1) an individual who, in the year of the indi-
23 vidual's initial eligibility to enroll in the CLASS pro-
24 gram, has elected to waive enrollment in the pro-
25 gram, is eligible to elect to enroll in the program, in

such form and manner as the Secretaries shall establish, only during an open enrollment period established by the Secretaries that is specific to the individual and that may not occur more frequently than biennially after the date on which the individual first elected to waive enrollment in the program; and

"(2) an individual shall only be permitted to disenroll from the program (other than for nonpayment of premiums) during an annual disenrollment period established by the Secretaries and in such form and manner as the Secretaries shall establish.

"SEC. 3205. BENEFITS.

"(a) DETERMINATION OF ELIGIBILITY.—

"(1) APPLICATION FOR RECEIPT OF BENEFITS.—The Secretary shall establish procedures under which an active enrollee shall apply for receipt of benefits under the CLASS Independence Benefit Plan.

"(2) ELIGIBILITY ASSESSMENTS.—

"(A) IN GENERAL.—Not later than January 1, 2012, the Secretary shall—

"(i) establish an Eligibility Assessment System (other than a service with which the Commissioner of Social Security

has entered into an agreement, with respect to any State, to make disability determinations for purposes of title II or XVI of the Social Security Act) to provide for eligibility assessments of active enrollees who apply for receipt of benefits;

"(ii) enter into an agreement with the Protection and Advocacy System for each State to provide advocacy services in accordance with subsection (d); and

"(iii) enter into an agreement with public and private entities to provide advice and assistance counseling in accordance with subsection (e).

"(B) REGULATIONS.—The Secretary shall promulgate regulations to develop an expedited nationally equitable eligibility determination process, as certified by a licensed health care practitioner, an appeals process, and a redetermination process, as certified by a licensed health care practitioner, including whether an active enrollee is eligible for a cash benefit under the program and if so, the amount of the cash benefit (in accordance the sliding scale established under the plan).

1 "(C) PRESUMPTIVE ELIGIBILITY FOR CER-
2 TAIN INSTITUTIONALIZED ENROLLEES PLAN-
3 NING TO DISCHARGE.—An active enrollee shall
4 be deemed presumptively eligible if the en-
5 rollee—
6 "(i) has applied for, and attests is eli-
7 gible for, the maximum cash benefit avail-
8 able under the sliding scale established
9 under the CLASS Independence Benefit
10 Plan;
11 "(ii) is a patient in a hospital (but
12 only if the hospitalization is for long-term
13 care), nursing facility, intermediate care
14 facility for the mentally retarded, or an in-
15 stitution for mental diseases; and
16 "(iii) is in the process of, or about to
17 begin the process of, planning to discharge
18 from the hospital, facility, or institution, or
19 within 60 days from the date of discharge
20 from the hospital, facility, or institution.
21 "(D) APPEALS.—The Secretary shall es-
22 tablish procedures under which an applicant for
23 benefits under the CLASS Independence Ben-
24 efit Plan shall be guaranteed the right to ap-
25 peal an adverse determination.

1 "(b) BENEFITS.—An eligible beneficiary shall receive
2 the following benefits under the CLASS Independence
3 Benefit Plan:
4 "(1) CASH BENEFIT.—A cash benefit estab-
5 lished by the Secretary in accordance with the re-
6 quirements of section 3203(a)(1)(D) that—
7 "(A) the first year in which beneficiaries
8 receive the benefits under the plan, is not less
9 than the average dollar amount specified in
10 clause (i) of such section; and
11 "(B) for any subsequent year, is not less
12 than the average per day dollar limit applicable
13 under this subparagraph for the preceding year,
14 increased by the percentage increase in the con-
15 sumer price index for all urban consumers
16 (U.S. city average) over the previous year.
17 "(2) ADVOCACY SERVICES.—Advocacy services
18 in accordance with subsection (d).
19 "(3) ADVICE AND ASSISTANCE COUNSELING.—
20 Advice and assistance counseling in accordance with
21 subsection (e).
22 "(4) ADMINISTRATIVE EXPENSES.—Advocacy
23 services and advise and assistance counseling serv-
24 ices under paragraphs (2) and (3) of this subsection

shall be included as administrative expenses under section 3203(b)(3).

"(c) PAYMENT OF BENEFITS.—

"(1) LIFE INDEPENDENCE ACCOUNT.—

"(A) IN GENERAL.—The Secretary shall establish procedures for administering the provision of benefits to eligible beneficiaries under the CLASS Independence Benefit Plan, including the payment of the cash benefit for the beneficiary into a Life Independence Account established by the Secretary on behalf of each eligible beneficiary.

"(B) USE OF CASH BENEFITS.—Cash benefits paid into a Life Independence Account of an eligible beneficiary shall be used to purchase nonmedical services and supports that the beneficiary needs to maintain his or her independence at home or in another residential setting of their choice in the community, including (but not limited to) home modifications, assistive technology, accessible transportation, homemaker services, respite care, personal assistance services, home care aides, and nursing support. Nothing in the preceding sentence shall prevent an eligible beneficiary from using cash benefits

1 paid into a Life Independence Account for ob-
2 taining assistance with decision making con-
3 cerning medical care, including the right to ac-
4 cept or refuse medical or surgical treatment
5 and the right to formulate advance directives or
6 other written instructions recognized under
7 State law, such as a living will or durable power
8 of attorney for health care, in the case that an
9 injury or illness causes the individual to be un-
10 able to make health care decisions.

11 "(C) ELECTRONIC MANAGEMENT OF
12 FUNDS.—The Secretary shall establish proce-
13 dures for—

14 "(i) crediting an account established
15 on behalf of a beneficiary with the bene-
16 ficiary's cash daily benefit;

17 "(ii) allowing the beneficiary to access
18 such account through debit cards; and

19 "(iii) accounting for withdrawals by
20 the beneficiary from such account.

21 "(D) PRIMARY PAYOR RULES FOR BENE-
22 FICIARIES WHO ARE ENROLLED IN MEDICAID.—
23 In the case of an eligible beneficiary who is en-
24 rolled in Medicaid, the following payment rules
25 shall apply:

"(i) INSTITUTIONALIZED BENEFICIARY.—If the beneficiary is a patient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or an institution for mental diseases, the beneficiary shall retain an amount equal to 5 percent of the beneficiary's daily or weekly cash benefit (as applicable) (which shall be in addition to the amount of the beneficiary's personal needs allowance provided under Medicaid), and the remainder of such benefit shall be applied toward the facility's cost of providing the beneficiary's care, and Medicaid shall provide secondary coverage for such care.

"(ii) BENEFICIARIES RECEIVING HOME AND COMMUNITY-BASED SERVICES.—

"(I) 50 PERCENT OF BENEFIT RETAINED BY BENEFICIARY.—Subject to subclause (II), if a beneficiary is receiving medical assistance under Medicaid for home and community based services, the beneficiary shall retain an amount equal to 50 percent

of the beneficiary's daily or weekly cash benefit (as applicable), and the remainder of the daily or weekly cash benefit shall be applied toward the cost to the State of providing such assistance (and shall not be used to claim Federal matching funds under Medicaid), and Medicaid shall provide secondary coverage for the remainder of any costs incurred in providing such assistance.

"(II) REQUIREMENT FOR STATE OFFSET.—A State shall be paid the remainder of a beneficiary's daily or weekly cash benefit under subclause (I) only if the State home and community-based waiver under section 1115 of the Social Security Act (42 U.S.C. 1315) or subsection (c) or (d) of section 1915 of such Act (42 U.S.C. 1396n), or the State plan amendment under subsection (i) of such section does not include a waiver of the requirements of section 1902(a)(1) of the Social Security Act

(relating to statewideness) or of section 1902(a)(10)(B) of such Act (relating to comparability) and the State offers at a minimum case management services, personal care services, habilitation services, and respite care under such a waiver or State plan amendment.

"(III) DEFINITION OF HOME AND COMMUNITY-BASED SERVICES.—In this clause, the term 'home and community-based services' means any services which may be offered under a home and community-based waiver authorized for a State under section 1115 of the Social Security Act (42 U.S.C. 1315) or subsection (c) or (d) of section 1915 of such Act (42 U.S.C. 1396n) or under a State plan amendment under subsection (i) of such section.

"(iii) BENEFICIARIES ENROLLED IN PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE).—

1 "(I) IN GENERAL.—Subject to
2 subclause (II), if a beneficiary is re-
3 ceiving medical assistance under Med-
4 icaid for PACE program services
5 under section 1934 of the Social Secu-
6 rity Act (42 U.S.C. 1396u–4), the
7 beneficiary shall retain an amount
8 equal to 50 percent of the bene-
9 ficiary's daily or weekly cash benefit
10 (as applicable), and the remainder of
11 the daily or weekly cash benefit shall
12 be applied toward the cost to the
13 State of providing such assistance
14 (and shall not be used to claim Fed-
15 eral matching funds under Medicaid),
16 and Medicaid shall provide secondary
17 coverage for the remainder of any
18 costs incurred in providing such as-
19 sistance.
20 "(II) INSTITUTIONALIZED RE-
21 CIPIENTS OF PACE PROGRAM SERV-
22 ICES.—If a beneficiary receiving as-
23 sistance under Medicaid for PACE
24 program services is a patient in a hos-
25 pital, nursing facility, intermediate

care facility for the mentally retarded, or an institution for mental diseases, the beneficiary shall be treated as in institutionalized beneficiary under clause (i).

"(2) AUTHORIZED REPRESENTATIVES.—

"(A) IN GENERAL.—The Secretary shall establish procedures to allow access to a beneficiary's cash benefits by an authorized representative of the eligible beneficiary on whose behalf such benefits are paid.

"(B) QUALITY ASSURANCE AND PROTECTION AGAINST FRAUD AND ABUSE.—The procedures established under subparagraph (A) shall ensure that authorized representatives of eligible beneficiaries comply with standards of conduct established by the Secretary, including standards requiring that such representatives provide quality services on behalf of such beneficiaries, do not have conflicts of interest, and do not misuse benefits paid on behalf of such beneficiaries or otherwise engage in fraud or abuse.

"(3) COMMENCEMENT OF BENEFITS.—Benefits shall be paid to, or on behalf of, an eligible bene-

ficiary beginning with the first month in which an application for such benefits is approved.

"(4) ROLLOVER OPTION FOR LUMP-SUM PAYMENT.—An eligible beneficiary may elect to—

"(A) defer payment of their daily or weekly benefit and to rollover any such deferred benefits from month-to-month, but not from year-to-year; and

"(B) receive a lump-sum payment of such deferred benefits in an amount that may not exceed the lesser of—

"(i) the total amount of the accrued deferred benefits; or

"(ii) the applicable annual benefit.

"(5) PERIOD FOR DETERMINATION OF ANNUAL BENEFITS.—

"(A) IN GENERAL.—The applicable period for determining with respect to an eligible beneficiary the applicable annual benefit and the amount of any accrued deferred benefits is the 12-month period that commences with the first month in which the beneficiary began to receive such benefits, and each 12-month period thereafter.

"(B) INCLUSION OF INCREASED BENEFITS.—The Secretary shall establish procedures under which cash benefits paid to an eligible beneficiary that increase or decrease as a result of a change in the functional status of the beneficiary before the end of a 12-month benefit period shall be included in the determination of the applicable annual benefit paid to the eligible beneficiary.

"(C) RECOUPMENT OF UNPAID, ACCRUED BENEFITS.—

"(i) IN GENERAL.—The Secretary, in coordination with the Secretary of the Treasury, shall recoup any accrued benefits in the event of—

"(I) the death of a beneficiary; or

"(II) the failure of a beneficiary to elect under paragraph (4)(B) to receive such benefits as a lump-sum payment before the end of the 12-month period in which such benefits accrued.

"(ii) PAYMENT INTO CLASS INDEPENDENCE FUND.—Any benefits recouped in accordance with clause (i) shall be paid

1 into the CLASS Independence Fund and
2 used in accordance with section 3206.
3 "(6) REQUIREMENT TO RECERTIFY ELIGIBILITY
4 FOR RECEIPT OF BENEFITS.—An eligible beneficiary
5 shall periodically, as determined by the Secretary—
6 "(A) recertify by submission of medical
7 evidence the beneficiary's continued eligibility
8 for receipt of benefits; and
9 "(B) submit records of expenditures attrib-
10 utable to the aggregate cash benefit received by
11 the beneficiary during the preceding year.
12 "(7) SUPPLEMENT, NOT SUPPLANT OTHER
13 HEALTH CARE BENEFITS.—Subject to the Medicaid
14 payment rules under paragraph (1)(D), benefits re-
15 ceived by an eligible beneficiary shall supplement,
16 but not supplant, other health care benefits for
17 which the beneficiary is eligible under Medicaid or
18 any other Federally funded program that provides
19 health care benefits or assistance.
20 "(d) ADVOCACY SERVICES.—An agreement entered
21 into under subsection (a)(2)(A)(ii) shall require the Pro-
22 tection and Advocacy System for the State to—
23 "(1) assign, as needed, an advocacy counselor
24 to each eligible beneficiary that is covered by such

1 agreement and who shall provide an eligible bene-
2 ficiary with—
3 "(A) information regarding how to access
4 the appeals process established for the program;
5 "(B) assistance with respect to the annual
6 recertification and notification required under
7 subsection (c)(6); and
8 "(C) such other assistance with obtaining
9 services as the Secretary, by regulation, shall
10 require; and
11 "(2) ensure that the System and such coun-
12 selors comply with the requirements of subsection
13 (h).
14 "(e) ADVICE AND ASSISTANCE COUNSELING.—An
15 agreement entered into under subsection (a)(2)(A)(iii)
16 shall require the entity to assign, as requested by an eligi-
17 ble beneficiary that is covered by such agreement, an ad-
18 vice and assistance counselor who shall provide an eligible
19 beneficiary with information regarding—
20 "(1) accessing and coordinating long-term serv-
21 ices and supports in the most integrated setting;
22 "(2) possible eligibility for other benefits and
23 services;
24 "(3) development of a service and support plan;

"(4) information about programs established under the Assistive Technology Act of 1998 and the services offered under such programs;

"(5) available assistance with decision making concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives or other written instructions recognized under State law, such as a living will or durable power of attorney for health care, in the case that an injury or illness causes the individual to be unable to make health care decisions; and

"(6) such other services as the Secretary, by regulation, may require.

"(f) NO EFFECT ON ELIGIBILITY FOR OTHER BENEFITS.—Benefits paid to an eligible beneficiary under the CLASS program shall be disregarded for purposes of determining or continuing the beneficiary's eligibility for receipt of benefits under any other Federal, State, or locally funded assistance program, including benefits paid under titles II, XVI, XVIII, XIX, or XXI of the Social Security Act (42 U.S.C. 401 et seq., 1381 et seq., 1395 et seq., 1396 et seq., 1397aa et seq.), under the laws administered by the Secretary of Veterans Affairs, under low-income housing assistance programs, or under the supplemental

1 nutrition assistance program established under the Food
2 and Nutrition Act of 2008 (7 U.S.C. 2011 et seq.).
3 "(g) RULE OF CONSTRUCTION.—Nothing in this title
4 shall be construed as prohibiting benefits paid under the
5 CLASS Independence Benefit Plan from being used to
6 compensate a family caregiver for providing community
7 living assistance services and supports to an eligible bene-
8 ficiary.
9 "(h) PROTECTION AGAINST CONFLICT OF INTER-
10 ESTS.—The Secretary shall establish procedures to ensure
11 that the Eligibility Assessment System, the Protection and
12 Advocacy System for a State, advocacy counselors for eli-
13 gible beneficiaries, and any other entities that provide
14 services to active enrollees and eligible beneficiaries under
15 the CLASS program comply with the following:
16 "(1) If the entity provides counseling or plan-
17 ning services, such services are provided in a manner
18 that fosters the best interests of the active enrollee
19 or beneficiary.
20 "(2) The entity has established operating proce-
21 dures that are designed to avoid or minimize con-
22 flicts of interest between the entity and an active en-
23 rollee or beneficiary.
24 "(3) The entity provides information about all
25 services and options available to the active enrollee

or beneficiary, to the best of its knowledge, including services available through other entities or providers.

''(4) The entity assists the active enrollee or beneficiary to access desired services, regardless of the provider.

''(5) The entity reports the number of active enrollees and beneficiaries provided with assistance by age, disability, and whether such enrollees and beneficiaries received services from the entity or another entity.

''(6) If the entity provides counseling or planning services, the entity ensures that an active enrollee or beneficiary is informed of any financial interest that the entity has in a service provider.

''(7) The entity provides an active enrollee or beneficiary with a list of available service providers that can meet the needs of the active enrollee or beneficiary.

''SEC. 3206. CLASS INDEPENDENCE FUND.

''(a) ESTABLISHMENT OF CLASS INDEPENDENCE FUND.—There is established in the Treasury of the United States a trust fund to be known as the 'CLASS Independence Fund'. The Secretary of the Treasury shall serve as Managing Trustee of such Fund. The Fund shall consist of all amounts derived from payments into the

1 Fund under sections 3204(f) and 3205(c)(5)(C)(ii), and
2 remaining after investment of such amounts under sub-
3 section (b), including additional amounts derived as in-
4 come from such investments. The amounts held in the
5 Fund are appropriated and shall remain available without
6 fiscal year limitation—

7 "(1) to be held for investment on behalf of indi-
8 viduals enrolled in the CLASS program;

9 "(2) to pay the administrative expenses related
10 to the Fund and to investment under subsection (b);
11 and

12 "(3) to pay cash benefits to eligible bene-
13 ficiaries under the CLASS Independence Benefit
14 Plan.

15 "(b) INVESTMENT OF FUND BALANCE.—The Sec-
16 retary of the Treasury shall invest and manage the
17 CLASS Independence Fund in the same manner, and to
18 the same extent, as the Federal Supplementary Medical
19 Insurance Trust Fund may be invested and managed
20 under subsections (c), (d), and (e) of section 1841(d) of
21 the Social Security Act (42 U.S.C. 1395t).

22 "(c) BOARD OF TRUSTEES.—

23 "(1) IN GENERAL.—With respect to the CLASS
24 Independence Fund, there is hereby created a body
25 to be known as the Board of Trustees of the CLASS

Independence Fund (hereinafter in this section referred to as the 'Board of Trustees') composed of the Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health and Human Services, all ex officio, and of two members of the public (both of whom may not be from the same political party), who shall be nominated by the President for a term of 4 years and subject to confirmation by the Senate. A member of the Board of Trustees serving as a member of the public and nominated and confirmed to fill a vacancy occurring during a term shall be nominated and confirmed only for the remainder of such term. An individual nominated and confirmed as a member of the public may serve in such position after the expiration of such member's term until the earlier of the time at which the member's successor takes office or the time at which a report of the Board is first issued under paragraph (2) after the expiration of the member's term. The Secretary of the Treasury shall be the Managing Trustee of the Board of Trustees. The Board of Trustees shall meet not less frequently than once each calendar year. A person serving on the Board of Trustees shall not be considered to be a fiduciary and shall not be personally liable for ac-

1 tions taken in such capacity with respect to the
2 Trust Fund.
3 "(2) DUTIES.—
4 "(A) IN GENERAL.—It shall be the duty of
5 the Board of Trustees to do the following:
6 "(i) Hold the CLASS Independence
7 Fund.
8 "(ii) Report to the Congress not later
9 than the first day of April of each year on
10 the operation and status of the CLASS
11 Independence Fund during the preceding
12 fiscal year and on its expected operation
13 and status during the current fiscal year
14 and the next 2 fiscal years.
15 "(iii) Report immediately to the Con-
16 gress whenever the Board is of the opinion
17 that the amount of the CLASS Independ-
18 ence Fund is not actuarially sound in re-
19 gards to the projection under section
20 3203(b)(1)(B)(i).
21 "(iv) Review the general policies fol-
22 lowed in managing the CLASS Independ-
23 ence Fund, and recommend changes in
24 such policies, including necessary changes
25 in the provisions of law which govern the

1 way in which the CLASS Independence
2 Fund is to be managed.
3 "(B) REPORT.—The report provided for in
4 subparagraph (A)(ii) shall—
5 "(i) include—
6 "(I) a statement of the assets of,
7 and the disbursements made from, the
8 CLASS Independence Fund during
9 the preceding fiscal year;
10 "(II) an estimate of the expected
11 income to, and disbursements to be
12 made from, the CLASS Independence
13 Fund during the current fiscal year
14 and each of the next 2 fiscal years;
15 "(III) a statement of the actu-
16 arial status of the CLASS Independ-
17 ence Fund for the current fiscal year,
18 each of the next 2 fiscal years, and as
19 projected over the 75-year period be-
20 ginning with the current fiscal year;
21 and
22 "(IV) an actuarial opinion by the
23 Chief Actuary of the Centers for
24 Medicare & Medicaid Services certi-
25 fying that the techniques and meth-

odologies used are generally accepted within the actuarial profession and that the assumptions and cost estimates used are reasonable; and

"(ii) be printed as a House document of the session of the Congress to which the report is made.

"(C) RECOMMENDATIONS.—If the Board of Trustees determines that enrollment trends and expected future benefit claims on the CLASS Independence Fund are not actuarially sound in regards to the projection under section 3203(b)(1)(B)(i) and are unlikely to be resolved with reasonable premium increases or through other means, the Board of Trustees shall include in the report provided for in subparagraph (A)(ii) recommendations for such legislative action as the Board of Trustees determine to be appropriate, including whether to adjust monthly premiums or impose a temporary moratorium on new enrollments.

"SEC. 3207. CLASS INDEPENDENCE ADVISORY COUNCIL.

"(a) ESTABLISHMENT.—There is hereby created an Advisory Committee to be known as the 'CLASS Independence Advisory Council'.

1 "(b) MEMBERSHIP.—

2 "(1) IN GENERAL.—The CLASS Independence
3 Advisory Council shall be composed of not more
4 than 15 individuals, not otherwise in the employ of
5 the United States—

6 "(A) who shall be appointed by the Presi-
7 dent without regard to the civil service laws and
8 regulations; and

9 "(B) a majority of whom shall be rep-
10 resentatives of individuals who participate or
11 are likely to participate in the CLASS program,
12 and shall include representatives of older and
13 younger workers, individuals with disabilities,
14 family caregivers of individuals who require
15 services and supports to maintain their inde-
16 pendence at home or in another residential set-
17 ting of their choice in the community, individ-
18 uals with expertise in long-term care or dis-
19 ability insurance, actuarial science, economics,
20 and other relevant disciplines, as determined by
21 the Secretary.

22 "(2) TERMS.—

23 "(A) IN GENERAL.—The members of the
24 CLASS Independence Advisory Council shall
25 serve overlapping terms of 3 years (unless ap-

pointed to fill a vacancy occurring prior to the expiration of a term, in which case the individual shall serve for the remainder of the term).

"(B) LIMITATION.—A member shall not be eligible to serve for more than 2 consecutive terms.

"(3) CHAIR.—The President shall, from time to time, appoint one of the members of the CLASS Independence Advisory Council to serve as the Chair.

"(c) DUTIES.—The CLASS Independence Advisory Council shall advise the Secretary on matters of general policy in the administration of the CLASS program established under this title and in the formulation of regulations under this title including with respect to—

"(1) the development of the CLASS Independence Benefit Plan under section 3203;

"(2) the determination of monthly premiums under such plan; and

"(3) the financial solvency of the program.

"(d) APPLICATION OF FACA.—The Federal Advisory Committee Act (5 U.S.C. App.), other than section 14 of that Act, shall apply to the CLASS Independence Advisory Council.

1 ''(e) AUTHORIZATION OF APPROPRIATIONS.—

2 ''(1) IN GENERAL.—There are authorized to be
3 appropriated to the CLASS Independence Advisory
4 Council to carry out its duties under this section,
5 such sums as may be necessary for fiscal year 2011
6 and for each fiscal year thereafter.

7 ''(2) AVAILABILITY.—Any sums appropriated
8 under the authorization contained in this section
9 shall remain available, without fiscal year limitation,
10 until expended.

11 **''SEC. 3208. SOLVENCY AND FISCAL INDEPENDENCE; REGU-**
12 **LATIONS; ANNUAL REPORT.**

13 ''(a) SOLVENCY.—The Secretary shall regularly con-
14 sult with the Board of Trustees of the CLASS Independ-
15 ence Fund and the CLASS Independence Advisory Coun-
16 cil, for purposes of ensuring that enrollees premiums are
17 adequate to ensure the financial solvency of the CLASS
18 program, both with respect to fiscal years occurring in the
19 near-term and fiscal years occurring over 20- and 75- year
20 periods, taking into account the projections required for
21 such periods under subsections (a)(1)(A)(i) and
22 (b)(1)(B)(i) of section 3202.

23 ''(b) NO TAXPAYER FUNDS USED TO PAY BENE-
24 FITS.—No taxpayer funds shall be used for payment of
25 benefits under a CLASS Independent Benefit Plan. For

1 purposes of this subsection, the term 'taxpayer funds'
2 means any Federal funds from a source other than pre-
3 miums deposited by CLASS program participants in the
4 CLASS Independence Fund and any associated interest
5 earnings.

6 ''(c) REGULATIONS.—The Secretary shall promulgate
7 such regulations as are necessary to carry out the CLASS
8 program in accordance with this title. Such regulations
9 shall include provisions to prevent fraud and abuse under
10 the program.

11 ''(d) ANNUAL REPORT.—Beginning January 1, 2014,
12 the Secretary shall submit an annual report to Congress
13 on the CLASS program. Each report shall include the fol-
14 lowing:

15 ''(1) The total number of enrollees in the pro-
16 gram.

17 ''(2) The total number of eligible beneficiaries
18 during the fiscal year.

19 ''(3) The total amount of cash benefits provided
20 during the fiscal year.

21 ''(4) A description of instances of fraud or
22 abuse identified during the fiscal year.

23 ''(5) Recommendations for such administrative
24 or legislative action as the Secretary determines is
25 necessary to improve the program, ensure the sol-

vency of the program, or to prevent the occurrence of fraud or abuse.

"SEC. 3209. INSPECTOR GENERAL'S REPORT.

''The Inspector General of the Department of Health and Human Services shall submit an annual report to the Secretary and Congress relating to the overall progress of the CLASS program and of the existence of waste, fraud, and abuse in the CLASS program. Each such report shall include findings in the following areas:

''(1) The eligibility determination process.

''(2) The provision of cash benefits.

''(3) Quality assurance and protection against waste, fraud, and abuse.

''(4) Recouping of unpaid and accrued benefits.

"SEC. 3210. TAX TREATMENT OF PROGRAM.

''The CLASS program shall be treated for purposes of the Internal Revenue Code of 1986 in the same manner as a qualified long-term care insurance contract for qualified long-term care services.''.

(2) CONFORMING AMENDMENTS TO MEDICAID.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by section 6505, is amended by inserting after paragraph (80) the following:

"(81) provide that the State will comply with such regulations regarding the application of primary and secondary payor rules with respect to individuals who are eligible for medical assistance under this title and are eligible beneficiaries under the CLASS program established under title XXXII of the Public Health Service Act as the Secretary shall establish; and".

(b) ASSURANCE OF ADEQUATE INFRASTRUCTURE FOR THE PROVISION OF PERSONAL CARE ATTENDANT WORKERS.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by subsection (a)(2), is amended by inserting after paragraph (81) the following:

"(82) provide that, not later than 2 years after the date of enactment of the Community Living Assistance Services and Supports Act, each State shall—

"(A) assess the extent to which entities such as providers of home care, home health services, home and community service providers, public authorities created to provide personal care services to individuals eligible for medical assistance under the State plan, and nonprofit organizations, are serving or have the capacity

to serve as fiscal agents for, employers of, and providers of employment-related benefits for, personal care attendant workers who provide personal care services to individuals receiving benefits under the CLASS program established under title XXXII of the Public Health Service Act, including in rural and underserved areas;

''(B) designate or create such entities to serve as fiscal agents for, employers of, and providers of employment-related benefits for, such workers to ensure an adequate supply of the workers for individuals receiving benefits under the CLASS program, including in rural and underserved areas; and

''(C) ensure that the designation or creation of such entities will not negatively alter or impede existing programs, models, methods, or administration of service delivery that provide for consumer controlled or self-directed home and community services and further ensure that such entities will not impede the ability of individuals to direct and control their home and community services, including the ability to select, manage, dismiss, co-employ, or employ such workers or inhibit such individuals from

relying on family members for the provision of personal care services.''.

(c) PERSONAL CARE ATTENDANTS WORKFORCE ADVISORY PANEL.—

(1) ESTABLISHMENT.—Not later than 90 days after the date of enactment of this Act, the Secretary of Health and Human Services shall establish a Personal Care Attendants Workforce Advisory Panel for the purpose of examining and advising the Secretary and Congress on workforce issues related to personal care attendant workers, including with respect to the adequacy of the number of such workers, the salaries, wages, and benefits of such workers, and access to the services provided by such workers.

(2) MEMBERSHIP.—In appointing members to the Personal Care Attendants Workforce Advisory Panel, the Secretary shall ensure that such members include the following:

(A) Individuals with disabilities of all ages.

(B) Senior individuals.

(C) Representatives of individuals with disabilities.

(D) Representatives of senior individuals.

(E) Representatives of workforce and labor organizations.

(F) Representatives of home and community-based service providers.

(G) Representatives of assisted living providers.

(d) INCLUSION OF INFORMATION ON SUPPLEMENTAL COVERAGE IN THE NATIONAL CLEARINGHOUSE FOR LONG-TERM CARE INFORMATION; EXTENSION OF FUNDING.—Section 6021(d) of the Deficit Reduction Act of 2005 (42 U.S.C. 1396p note) is amended—

(1) in paragraph (2)(A)—

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

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

(C) by adding at the end the following:

''(iv) include information regarding the CLASS program established under title XXXII of the Public Health Service Act and coverage available for purchase through a Exchange established under section 1311 of the Patient Protection and Affordable Care Act that is supplemental coverage to the benefits provided under a

CLASS Independence Benefit Plan under that program, and information regarding how benefits provided under a CLASS Independence Benefit Plan differ from disability insurance benefits.''; and

(2) in paragraph (3), by striking ''2010'' and inserting ''2015''.

(e) EFFECTIVE DATE.—The amendments made by subsections (a), (b), and (d) take effect on January 1, 2011.

(f) RULE OF CONSTRUCTION.—Nothing in this title or the amendments made by this title are intended to replace or displace public or private disability insurance benefits, including such benefits that are for income replacement.

TITLE IX—REVENUE PROVISIONS

Subtitle A—Revenue Offset Provisions

SEC. 9001. EXCISE TAX ON HIGH COST EMPLOYER-SPONSORED HEALTH COVERAGE.

(a) IN GENERAL.—Chapter 43 of the Internal Revenue Code of 1986, as amended by section 1513, is amended by adding at the end the following:

"SEC. 4980I. EXCISE TAX ON HIGH COST EMPLOYER-SPONSORED HEALTH COVERAGE.

"(a) IMPOSITION OF TAX.—If—

"(1) an employee is covered under any applicable employer-sponsored coverage of an employer at any time during a taxable period, and

"(2) there is any excess benefit with respect to the coverage,

there is hereby imposed a tax equal to 40 percent of the excess benefit.

"(b) EXCESS BENEFIT.—For purposes of this section—

"(1) IN GENERAL.—The term 'excess benefit' means, with respect to any applicable employer-sponsored coverage made available by an employer to an employee during any taxable period, the sum of the excess amounts determined under paragraph (2) for months during the taxable period.

"(2) MONTHLY EXCESS AMOUNT.—The excess amount determined under this paragraph for any month is the excess (if any) of—

"(A) the aggregate cost of the applicable employer-sponsored coverage of the employee for the month, over

"(B) an amount equal to 1/12 of the annual limitation under paragraph (3) for the calendar year in which the month occurs.

"(3) ANNUAL LIMITATION.—For purposes of this subsection—

"(A) IN GENERAL.—The annual limitation under this paragraph for any calendar year is the dollar limit determined under subparagraph (C) for the calendar year.

"(B) APPLICABLE ANNUAL LIMITATION.—The annual limitation which applies for any month shall be determined on the basis of the type of coverage (as determined under subsection (f)(1)) provided to the employee by the employer as of the beginning of the month.

"(C) APPLICABLE DOLLAR LIMIT.—Except as provided in subparagraph (D)—

"(i) 2013.—In the case of 2013, the dollar limit under this subparagraph is—

"(I) in the case of an employee with self-only coverage, $8,500, and

"(II) in the case of an employee with coverage other than self-only coverage, $23,000.

"(ii) EXCEPTION FOR CERTAIN INDIVIDUALS.—In the case of an individual who is a qualified retiree or who participates in a plan sponsored by an employer the majority of whose employees are engaged in a high-risk profession or employed to repair or install electrical or telecommunications lines—

"(I) the dollar amount in clause (i)(I) (determined after the application of subparagraph (D)) shall be increased by $1,350, and

"(II) the dollar amount in clause (i)(II) (determined after the application of subparagraph (D)) shall be increased by $3,000.

"(iii) SUBSEQUENT YEARS.—In the case of any calendar year after 2013, each of the dollar amounts under clauses (i) and (ii) shall be increased to the amount equal to such amount as in effect for the calendar year preceding such year, increased by an amount equal to the product of—

"(I) such amount as so in effect, multiplied by

"(II) the cost-of-living adjustment determined under section 1(f)(3) for such year (determined by substituting the calendar year that is 2 years before such year for '1992' in subparagraph (B) thereof), increased by 1 percentage point.

If any amount determined under this clause is not a multiple of $50, such amount shall be rounded to the nearest multiple of $50.

"(D) TRANSITION RULE FOR STATES WITH HIGHEST COVERAGE COSTS.—

"(i) IN GENERAL.—If an employee is a resident of a high cost State on the first day of any month beginning in 2013, 2014, or 2015, the annual limitation under this paragraph for such month with respect to such employee shall be an amount equal to the applicable percentage of the annual limitation (determined without regard to this subparagraph or subparagraph (C)(ii)).

"(ii) APPLICABLE PERCENTAGE.—The applicable percentage is 120 percent for

2013, 110 percent for 2014, and 105 percent for 2015.

"(iii) HIGH COST STATE.—The term 'high cost State' means each of the 17 States which the Secretary of Health and Human Services, in consultation with the Secretary, estimates had the highest average cost during 2012 for employer-sponsored coverage under health plans. The Secretary's estimate shall be made on the basis of aggregate premiums paid in the State for such health plans, determined using the most recent data available as of August 31, 2012.

"(c) LIABILITY TO PAY TAX.—

"(1) IN GENERAL.—Each coverage provider shall pay the tax imposed by subsection (a) on its applicable share of the excess benefit with respect to an employee for any taxable period.

"(2) COVERAGE PROVIDER.—For purposes of this subsection, the term 'coverage provider' means each of the following:

"(A) HEALTH INSURANCE COVERAGE.—If the applicable employer-sponsored coverage consists of coverage under a group health plan

which provides health insurance coverage, the health insurance issuer.

"(B) HSA AND MSA CONTRIBUTIONS.—If the applicable employer-sponsored coverage consists of coverage under an arrangement under which the employer makes contributions described in subsection (b) or (d) of section 106, the employer.

"(C) OTHER COVERAGE.—In the case of any other applicable employer-sponsored coverage, the person that administers the plan benefits.

"(3) APPLICABLE SHARE.—For purposes of this subsection, a coverage provider's applicable share of an excess benefit for any taxable period is the amount which bears the same ratio to the amount of such excess benefit as—

"(A) the cost of the applicable employer-sponsored coverage provided by the provider to the employee during such period, bears to

"(B) the aggregate cost of all applicable employer-sponsored coverage provided to the employee by all coverage providers during such period.

1 "(4) RESPONSIBILITY TO CALCULATE TAX AND
2 APPLICABLE SHARES.—
3 "(A) IN GENERAL.—Each employer shall—
4 "(i) calculate for each taxable period
5 the amount of the excess benefit subject to
6 the tax imposed by subsection (a) and the
7 applicable share of such excess benefit for
8 each coverage provider, and
9 "(ii) notify, at such time and in such
10 manner as the Secretary may prescribe,
11 the Secretary and each coverage provider
12 of the amount so determined for the pro-
13 vider.
14 "(B) SPECIAL RULE FOR MULTIEMPLOYER
15 PLANS.—In the case of applicable employer-
16 sponsored coverage made available to employees
17 through a multiemployer plan (as defined in
18 section 414(f)), the plan sponsor shall make the
19 calculations, and provide the notice, required
20 under subparagraph (A).
21 "(d) APPLICABLE EMPLOYER-SPONSORED COV-
22 ERAGE; COST.—For purposes of this section—
23 "(1) APPLICABLE EMPLOYER-SPONSORED COV-
24 ERAGE.—

"(A) IN GENERAL.—The term 'applicable employer-sponsored coverage' means, with respect to any employee, coverage under any group health plan made available to the employee by an employer which is excludable from the employee's gross income under section 106, or would be so excludable if it were employer-provided coverage (within the meaning of such section 106).

"(B) EXCEPTIONS.—The term 'applicable employer-sponsored coverage' shall not include—

"(i) any coverage (whether through insurance or otherwise) described in section 9832(c)(1)(A) or for long-term care, or

"(ii) any coverage described in section 9832(c)(3) the payment for which is not excludable from gross income and for which a deduction under section 162(l) is not allowable.

"(C) COVERAGE INCLUDES EMPLOYEE PAID PORTION.—Coverage shall be treated as applicable employer-sponsored coverage without

regard to whether the employer or employee pays for the coverage.

"(D) SELF-EMPLOYED INDIVIDUAL.—In the case of an individual who is an employee within the meaning of section 401(c)(1), coverage under any group health plan providing health insurance coverage shall be treated as applicable employer-sponsored coverage if a deduction is allowable under section 162(l) with respect to all or any portion of the cost of the coverage.

"(E) GOVERNMENTAL PLANS INCLUDED.—Applicable employer-sponsored coverage shall include coverage under any group health plan established and maintained primarily for its civilian employees by the Government of the United States, by the government of any State or political subdivision thereof, or by any agency or instrumentality of any such government.

"(2) DETERMINATION OF COST.—

"(A) IN GENERAL.—The cost of applicable employer-sponsored coverage shall be determined under rules similar to the rules of section 4980B(f)(4), except that in determining such cost, any portion of the cost of such coverage

which is attributable to the tax imposed under this section shall not be taken into account and the amount of such cost shall be calculated separately for self-only coverage and other coverage. In the case of applicable employer-sponsored coverage which provides coverage to retired employees, the plan may elect to treat a retired employee who has not attained the age of 65 and a retired employee who has attained the age of 65 as similarly situated beneficiaries.

"(B) HEALTH FSAS.—In the case of applicable employer-sponsored coverage consisting of coverage under a flexible spending arrangement (as defined in section 106(c)(2)), the cost of the coverage shall be equal to the sum of—

"(i) the amount of employer contributions under any salary reduction election under the arrangement, plus

"(ii) the amount determined under subparagraph (A) with respect to any reimbursement under the arrangement in excess of the contributions described in clause (i).

"(C) ARCHER MSAS AND HSAS.—In the case of applicable employer-sponsored coverage

consisting of coverage under an arrangement under which the employer makes contributions described in subsection (b) or (d) of section 106, the cost of the coverage shall be equal to the amount of employer contributions under the arrangement.

"(D) ALLOCATION ON A MONTHLY BASIS.—If cost is determined on other than a monthly basis, the cost shall be allocated to months in a taxable period on such basis as the Secretary may prescribe.

"(e) PENALTY FOR FAILURE TO PROPERLY CALCULATE EXCESS BENEFIT.—

"(1) IN GENERAL.—If, for any taxable period, the tax imposed by subsection (a) exceeds the tax determined under such subsection with respect to the total excess benefit calculated by the employer or plan sponsor under subsection (c)(4)—

"(A) each coverage provider shall pay the tax on its applicable share (determined in the same manner as under subsection (c)(4)) of the excess, but no penalty shall be imposed on the provider with respect to such amount, and

"(B) the employer or plan sponsor shall, in addition to any tax imposed by subsection (a),

pay a penalty in an amount equal to such excess, plus interest at the underpayment rate determined under section 6621 for the period beginning on the due date for the payment of tax imposed by subsection (a) to which the excess relates and ending on the date of payment of the penalty.

"(2) LIMITATIONS ON PENALTY.—

"(A) PENALTY NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No penalty shall be imposed by paragraph (1)(B) on any failure to properly calculate the excess benefit during any period for which it is established to the satisfaction of the Secretary that the employer or plan sponsor neither knew, nor exercising reasonable diligence would have known, that such failure existed.

"(B) PENALTY NOT TO APPLY TO FAILURES CORRECTED WITHIN 30 DAYS.—No penalty shall be imposed by paragraph (1)(B) on any such failure if—

"(i) such failure was due to reasonable cause and not to willful neglect, and

"(ii) such failure is corrected during the 30-day period beginning on the 1st date that the employer knew, or exercising reasonable diligence would have known, that such failure existed.

"(C) WAIVER BY SECRETARY.—In the case of any such failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the penalty imposed by paragraph (1), to the extent that the payment of such penalty would be excessive or otherwise inequitable relative to the failure involved.

"(f) OTHER DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

"(1) COVERAGE DETERMINATIONS.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), an employee shall be treated as having self-only coverage with respect to any applicable employer-sponsored coverage of an employer.

"(B) MINIMUM ESSENTIAL COVERAGE.—An employee shall be treated as having coverage other than self-only coverage only if the employee is enrolled in coverage other than self-only coverage in a group health plan which pro-

vides minimum essential coverage (as defined in section 5000A(f)) to the employee and at least one other beneficiary, and the benefits provided under such minimum essential coverage do not vary based on whether any individual covered under such coverage is the employee or another beneficiary.

"(2) QUALIFIED RETIREE.—The term 'qualified retiree' means any individual who—

"(A) is receiving coverage by reason of being a retiree,

"(B) has attained age 55, and

"(C) is not entitled to benefits or eligible for enrollment under the Medicare program under title XVIII of the Social Security Act.

"(3) EMPLOYEES ENGAGED IN HIGH-RISK PROFESSION.—The term 'employees engaged in a high-risk profession' means law enforcement officers (as such term is defined in section 1204 of the Omnibus Crime Control and Safe Streets Act of 1968), employees in fire protection activities (as such term is defined in section 3(y) of the Fair Labor Standards Act of 1938), individuals who provide out-of-hospital emergency medical care (including emergency medical technicians, paramedics, and first-responders),

and individuals engaged in the construction, mining, agriculture (not including food processing), forestry, and fishing industries. Such term includes an employee who is retired from a high-risk profession described in the preceding sentence, if such employee satisfied the requirements of such sentence for a period of not less than 20 years during the employee's employment.

"(4) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning given such term by section 5000(b)(1).

"(5) HEALTH INSURANCE COVERAGE; HEALTH INSURANCE ISSUER.—

"(A) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning given such term by section 9832(b)(1) (applied without regard to subparagraph (B) thereof, except as provided by the Secretary in regulations).

"(B) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning given such term by section 9832(b)(2).

"(6) PERSON THAT ADMINISTERS THE PLAN BENEFITS.—The term 'person that administers the

1 plan benefits' shall include the plan sponsor if the
2 plan sponsor administers benefits under the plan.
3 "(7) PLAN SPONSOR.—The term 'plan sponsor'
4 has the meaning given such term in section 3(16)(B)
5 of the Employee Retirement Income Security Act of
6 1974.
7 "(8) TAXABLE PERIOD.—The term 'taxable pe-
8 riod' means the calendar year or such shorter period
9 as the Secretary may prescribe. The Secretary may
10 have different taxable periods for employers of vary-
11 ing sizes.
12 "(9) AGGREGATION RULES.—All employers
13 treated as a single employer under subsection (b),
14 (c), (m), or (o) of section 414 shall be treated as a
15 single employer.
16 "(10) DENIAL OF DEDUCTION.—For denial of a
17 deduction for the tax imposed by this section, see
18 section 275(a)(6).
19 "(g) REGULATIONS.—The Secretary shall prescribe
20 such regulations as may be necessary to carry out this
21 section.".
22 (b) CLERICAL AMENDMENT.—The table of sections
23 for chapter 43 of such Code, as amended by section 1513,
24 is amended by adding at the end the following new item:

"Sec. 4980I. Excise tax on high cost employer-sponsored health coverage.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2012.

SEC. 9002. INCLUSION OF COST OF EMPLOYER-SPONSORED HEALTH COVERAGE ON W–2.

(a) IN GENERAL.—Section 6051(a) of the Internal Revenue Code of 1986 (relating to receipts for employees) is amended by striking ''and'' at the end of paragraph (12), by striking the period at the end of paragraph (13) and inserting '', and'', and by adding after paragraph (13) the following new paragraph:

''(14) the aggregate cost (determined under rules similar to the rules of section 4980B(f)(4)) of applicable employer-sponsored coverage (as defined in section 4980I(d)(1)), except that this paragraph shall not apply to—

''(A) coverage to which paragraphs (11) and (12) apply, or

''(B) the amount of any salary reduction contributions to a flexible spending arrangement (within the meaning of section 125).''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2010.

SEC. 9003. DISTRIBUTIONS FOR MEDICINE QUALIFIED ONLY IF FOR PRESCRIBED DRUG OR INSULIN.

(a) HSAs.—Subparagraph (A) of section 223(d)(2) of the Internal Revenue Code of 1986 is amended by adding at the end the following: ''Such term shall include an amount paid for medicine or a drug only if such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin.''.

(b) ARCHER MSAs.—Subparagraph (A) of section 220(d)(2) of the Internal Revenue Code of 1986 is amended by adding at the end the following: ''Such term shall include an amount paid for medicine or a drug only if such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin.''.

(c) HEALTH FLEXIBLE SPENDING ARRANGEMENTS AND HEALTH REIMBURSEMENT ARRANGEMENTS.—Section 106 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

''(f) REIMBURSEMENTS FOR MEDICINE RESTRICTED TO PRESCRIBED DRUGS AND INSULIN.—For purposes of this section and section 105, reimbursement for expenses incurred for a medicine or a drug shall be treated as a reimbursement for medical expenses only if such medicine

or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin.''.

(d) EFFECTIVE DATES.—

(1) DISTRIBUTIONS FROM SAVINGS ACCOUNTS.—The amendments made by subsections (a) and (b) shall apply to amounts paid with respect to taxable years beginning after December 31, 2010.

(2) REIMBURSEMENTS.—The amendment made by subsection (c) shall apply to expenses incurred with respect to taxable years beginning after December 31, 2010.

SEC. 9004. INCREASE IN ADDITIONAL TAX ON DISTRIBUTIONS FROM HSAS AND ARCHER MSAS NOT USED FOR QUALIFIED MEDICAL EXPENSES.

(a) HSAS.—Section 223(f)(4)(A) of the Internal Revenue Code of 1986 is amended by striking ''10 percent'' and inserting ''20 percent''.

(b) ARCHER MSAS.—Section 220(f)(4)(A) of the Internal Revenue Code of 1986 is amended by striking ''15 percent'' and inserting ''20 percent''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to distributions made after December 31, 2010.

SEC. 9005. LIMITATION ON HEALTH FLEXIBLE SPENDING ARRANGEMENTS UNDER CAFETERIA PLANS.

(a) IN GENERAL.—Section 125 of the Internal Revenue Code of 1986 is amended—

(1) by redesignating subsections (i) and (j) as subsections (j) and (k), respectively, and

(2) by inserting after subsection (h) the following new subsection:

''(i) LIMITATION ON HEALTH FLEXIBLE SPENDING ARRANGEMENTS.—For purposes of this section, if a benefit is provided under a cafeteria plan through employer contributions to a health flexible spending arrangement, such benefit shall not be treated as a qualified benefit unless the cafeteria plan provides that an employee may not elect for any taxable year to have salary reduction contributions in excess of $2,500 made to such arrangement.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2010.

SEC. 9006. EXPANSION OF INFORMATION REPORTING REQUIREMENTS.

(a) IN GENERAL.—Section 6041 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsections:

"(h) APPLICATION TO CORPORATIONS.—Notwithstanding any regulation prescribed by the Secretary before the date of the enactment of this subsection, for purposes of this section the term 'person' includes any corporation that is not an organization exempt from tax under section 501(a).

"(i) REGULATIONS.—The Secretary may prescribe such regulations and other guidance as may be appropriate or necessary to carry out the purposes of this section, including rules to prevent duplicative reporting of transactions.".

(b) PAYMENTS FOR PROPERTY AND OTHER GROSS PROCEEDS.—Subsection (a) of section 6041 of the Internal Revenue Code of 1986 is amended—

(1) by inserting "amounts in consideration for property," after "wages,",

(2) by inserting "gross proceeds," after "emoluments, or other", and

(3) by inserting "gross proceeds," after "setting forth the amount of such".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to payments made after December 31, 2011.

SEC. 9007. ADDITIONAL REQUIREMENTS FOR CHARITABLE HOSPITALS.

(a) REQUIREMENTS TO QUALIFY AS SECTION 501(C)(3) CHARITABLE HOSPITAL ORGANIZATION.—Section 501 of the Internal Revenue Code of 1986 (relating to exemption from tax on corporations, certain trusts, etc.) is amended by redesignating subsection (r) as subsection (s) and by inserting after subsection (q) the following new subsection:

"(r) ADDITIONAL REQUIREMENTS FOR CERTAIN HOSPITALS.—

"(1) IN GENERAL.—A hospital organization to which this subsection applies shall not be treated as described in subsection (c)(3) unless the organization—

"(A) meets the community health needs assessment requirements described in paragraph (3),

"(B) meets the financial assistance policy requirements described in paragraph (4),

"(C) meets the requirements on charges described in paragraph (5), and

"(D) meets the billing and collection requirement described in paragraph (6).

"(2) HOSPITAL ORGANIZATIONS TO WHICH SUBSECTION APPLIES.—

"(A) IN GENERAL.—This subsection shall apply to—

"(i) an organization which operates a facility which is required by a State to be licensed, registered, or similarly recognized as a hospital, and

"(ii) any other organization which the Secretary determines has the provision of hospital care as its principal function or purpose constituting the basis for its exemption under subsection (c)(3) (determined without regard to this subsection).

"(B) ORGANIZATIONS WITH MORE THAN 1 HOSPITAL FACILITY.—If a hospital organization operates more than 1 hospital facility—

"(i) the organization shall meet the requirements of this subsection separately with respect to each such facility, and

"(ii) the organization shall not be treated as described in subsection (c)(3) with respect to any such facility for which such requirements are not separately met.

"(3) COMMUNITY HEALTH NEEDS ASSESSMENTS.—

"(A) IN GENERAL.—An organization meets the requirements of this paragraph with respect to any taxable year only if the organization—

"(i) has conducted a community health needs assessment which meets the requirements of subparagraph (B) in such taxable year or in either of the 2 taxable years immediately preceding such taxable year, and

"(ii) has adopted an implementation strategy to meet the community health needs identified through such assessment.

"(B) COMMUNITY HEALTH NEEDS ASSESSMENT.—A community health needs assessment meets the requirements of this paragraph if such community health needs assessment—

"(i) takes into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health, and

"(ii) is made widely available to the public.

"(4) FINANCIAL ASSISTANCE POLICY.—An organization meets the requirements of this paragraph if the organization establishes the following policies:

"(A) FINANCIAL ASSISTANCE POLICY.—A written financial assistance policy which includes—

"(i) eligibility criteria for financial assistance, and whether such assistance includes free or discounted care,

"(ii) the basis for calculating amounts charged to patients,

"(iii) the method for applying for financial assistance,

"(iv) in the case of an organization which does not have a separate billing and collections policy, the actions the organization may take in the event of non-payment, including collections action and reporting to credit agencies, and

"(v) measures to widely publicize the policy within the community to be served by the organization.

"(B) POLICY RELATING TO EMERGENCY MEDICAL CARE.—A written policy requiring the organization to provide, without discrimination,

care for emergency medical conditions (within the meaning of section 1867 of the Social Security Act (42 U.S.C. 1395dd)) to individuals regardless of their eligibility under the financial assistance policy described in subparagraph (A).

"(5) LIMITATION ON CHARGES.—An organization meets the requirements of this paragraph if the organization—

"(A) limits amounts charged for emergency or other medically necessary care provided to individuals eligible for assistance under the financial assistance policy described in paragraph (4)(A) to not more than the lowest amounts charged to individuals who have insurance covering such care, and

"(B) prohibits the use of gross charges.

"(6) BILLING AND COLLECTION REQUIREMENTS.—An organization meets the requirement of this paragraph only if the organization does not engage in extraordinary collection actions before the organization has made reasonable efforts to determine whether the individual is eligible for assistance under the financial assistance policy described in paragraph (4)(A).

"(7) REGULATORY AUTHORITY.—The Secretary shall issue such regulations and guidance as may be necessary to carry out the provisions of this subsection, including guidance relating to what constitutes reasonable efforts to determine the eligibility of a patient under a financial assistance policy for purposes of paragraph (6).".

(b) EXCISE TAX FOR FAILURES TO MEET HOSPITAL EXEMPTION REQUIREMENTS.—

(1) IN GENERAL.—Subchapter D of chapter 42 of the Internal Revenue Code of 1986 (relating to failure by certain charitable organizations to meet certain qualification requirements) is amended by adding at the end the following new section:

"SEC. 4959. TAXES ON FAILURES BY HOSPITAL ORGANIZATIONS.

"If a hospital organization to which section 501(r) applies fails to meet the requirement of section 501(r)(3) for any taxable year, there is imposed on the organization a tax equal to $50,000.".

(2) CONFORMING AMENDMENT.—The table of sections for subchapter D of chapter 42 of such Code is amended by adding at the end the following new item:

"Sec. 4959. Taxes on failures by hospital organizations.".

(c) MANDATORY REVIEW OF TAX EXEMPTION FOR HOSPITALS.—The Secretary of the Treasury or the Secretary's delegate shall review at least once every 3 years the community benefit activities of each hospital organization to which section 501(r) of the Internal Revenue Code of 1986 (as added by this section) applies.

(d) ADDITIONAL REPORTING REQUIREMENTS.—

(1) COMMUNITY HEALTH NEEDS ASSESSMENTS AND AUDITED FINANCIAL STATEMENTS.—Section 6033(b) of the Internal Revenue Code of 1986 (relating to certain organizations described in section 501(c)(3)) is amended by striking ''and'' at the end of paragraph (14), by redesignating paragraph (15) as paragraph (16), and by inserting after paragraph (14) the following new paragraph:

''(15) in the case of an organization to which the requirements of section 501(r) apply for the taxable year—

''(A) a description of how the organization is addressing the needs identified in each community health needs assessment conducted under section 501(r)(3) and a description of any such needs that are not being addressed together with the reasons why such needs are not being addressed, and

"(B) the audited financial statements of such organization (or, in the case of an organization the financial statements of which are included in a consolidated financial statement with other organizations, such consolidated financial statement).".

(2) TAXES.—Section 6033(b)(10) of such Code is amended by striking "and" at the end of subparagraph (B), by inserting "and" at the end of subparagraph (C), and by adding at the end the following new subparagraph:

"(D) section 4959 (relating to taxes on failures by hospital organizations),".

(e) REPORTS.—

(1) REPORT ON LEVELS OF CHARITY CARE.—The Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, shall submit to the Committees on Ways and Means, Education and Labor, and Energy and Commerce of the House of Representatives and to the Committees on Finance and Health, Education, Labor, and Pensions of the Senate an annual report on the following:

(A) Information with respect to private tax-exempt, taxable, and government-owned hospitals regarding—

(i) levels of charity care provided,

(ii) bad debt expenses,

(iii) unreimbursed costs for services provided with respect to means-tested government programs, and

(iv) unreimbursed costs for services provided with respect to non-means tested government programs.

(B) Information with respect to private tax-exempt hospitals regarding costs incurred for community benefit activities.

(2) REPORT ON TRENDS.—

(A) STUDY.—The Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, shall conduct a study on trends in the information required to be reported under paragraph (1).

(B) REPORT.—Not later than 5 years after the date of the enactment of this Act, the Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, shall submit a report on the study conducted under

subparagraph (A) to the Committees on Ways and Means, Education and Labor, and Energy and Commerce of the House of Representatives and to the Committees on Finance and Health, Education, Labor, and Pensions of the Senate.

(f) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in paragraphs (2) and (3), the amendments made by this section shall apply to taxable years beginning after the date of the enactment of this Act.

(2) COMMUNITY HEALTH NEEDS ASSESSMENT.—The requirements of section 501(r)(3) of the Internal Revenue Code of 1986, as added by subsection (a), shall apply to taxable years beginning after the date which is 2 years after the date of the enactment of this Act.

(3) EXCISE TAX.—The amendments made by subsection (b) shall apply to failures occurring after the date of the enactment of this Act.

SEC. 9008. IMPOSITION OF ANNUAL FEE ON BRANDED PRESCRIPTION PHARMACEUTICAL MANUFACTURERS AND IMPORTERS.

(a) IMPOSITION OF FEE.—

(1) IN GENERAL.—Each covered entity engaged in the business of manufacturing or importing

branded prescription drugs shall pay to the Secretary of the Treasury not later than the annual payment date of each calendar year beginning after 2009 a fee in an amount determined under subsection (b).

(2) ANNUAL PAYMENT DATE.—For purposes of this section, the term ''annual payment date'' means with respect to any calendar year the date determined by the Secretary, but in no event later than September 30 of such calendar year.

(b) DETERMINATION OF FEE AMOUNT.—

(1) IN GENERAL.—With respect to each covered entity, the fee under this section for any calendar year shall be equal to an amount that bears the same ratio to $2,300,000,000 as—

(A) the covered entity's branded prescription drug sales taken into account during the preceding calendar year, bear to

(B) the aggregate branded prescription drug sales of all covered entities taken into account during such preceding calendar year.

(2) SALES TAKEN INTO ACCOUNT.—For purposes of paragraph (1), the branded prescription drug sales taken into account during any calendar

1 year with respect to any covered entity shall be de-
2 termined in accordance with the following table:

With respect to a covered entity's aggregate branded prescription drug sales during the calendar year that are:	The percentage of such sales taken into account is:
Not more than $5,000,000	0 percent
More than $5,000,000 but not more than $125,000,000.	10 percent
More than $125,000,000 but not more than $225,000,000.	40 percent
More than $225,000,000 but not more than $400,000,000.	75 percent
More than $400,000,000	100 percent.

3 (3) SECRETARIAL DETERMINATION.—The Sec-
4 retary of the Treasury shall calculate the amount of
5 each covered entity's fee for any calendar year under
6 paragraph (1). In calculating such amount, the Sec-
7 retary of the Treasury shall determine such covered
8 entity's branded prescription drug sales on the basis
9 of reports submitted under subsection (g) and
10 through the use of any other source of information
11 available to the Secretary of the Treasury.
12 (c) TRANSFER OF FEES TO MEDICARE PART B
13 TRUST FUND.—There is hereby appropriated to the Fed-
14 eral Supplementary Medical Insurance Trust Fund estab-
15 lished under section 1841 of the Social Security Act an
16 amount equal to the fees received by the Secretary of the
17 Treasury under subsection (a).
18 (d) COVERED ENTITY.—

(1) IN GENERAL.—For purposes of this section, the term ''covered entity'' means any manufacturer or importer with gross receipts from branded prescription drug sales.

(2) CONTROLLED GROUPS.—

(A) IN GENERAL.—For purposes of this subsection, all persons treated as a single employer under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 or subsection (m) or (o) of section 414 of such Code shall be treated as a single covered entity.

(B) INCLUSION OF FOREIGN CORPORATIONS.—For purposes of subparagraph (A), in applying subsections (a) and (b) of section 52 of such Code to this section, section 1563 of such Code shall be applied without regard to subsection (b)(2)(C) thereof.

(e) BRANDED PRESCRIPTION DRUG SALES.—For purposes of this section—

(1) IN GENERAL.—The term ''branded prescription drug sales'' means sales of branded prescription drugs to any specified government program or pursuant to coverage under any such program.

(2) BRANDED PRESCRIPTION DRUGS.—

(A) IN GENERAL.—The term ''branded prescription drug'' means—

(i) any prescription drug the application for which was submitted under section 505(b) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(b)), or

(ii) any biological product the license for which was submitted under section 351(a) of the Public Health Service Act (42 U.S.C. 262(a)).

(B) PRESCRIPTION DRUG.—For purposes of subparagraph (A)(i), the term ''prescription drug'' means any drug which is subject to section 503(b) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 353(b)).

(3) EXCLUSION OF ORPHAN DRUG SALES.—The term ''branded prescription drug sales'' shall not include sales of any drug or biological product with respect to which a credit was allowed for any taxable year under section 45C of the Internal Revenue Code of 1986. The preceding sentence shall not apply with respect to any such drug or biological product after the date on which such drug or biological product is approved by the Food and Drug Administration for marketing for any indication

other than the treatment of the rare disease or condition with respect to which such credit was allowed.

(4) SPECIFIED GOVERNMENT PROGRAM.—The term ''specified government program'' means—

(A) the Medicare Part D program under part D of title XVIII of the Social Security Act,

(B) the Medicare Part B program under part B of title XVIII of the Social Security Act,

(C) the Medicaid program under title XIX of the Social Security Act,

(D) any program under which branded prescription drugs are procured by the Department of Veterans Affairs,

(E) any program under which branded prescription drugs are procured by the Department of Defense, or

(F) the TRICARE retail pharmacy program under section 1074g of title 10, United States Code.

(f) TAX TREATMENT OF FEES.—The fees imposed by this section—

(1) for purposes of subtitle F of the Internal Revenue Code of 1986, shall be treated as excise taxes with respect to which only civil actions for re-

fund under procedures of such subtitle shall apply, and

(2) for purposes of section 275 of such Code, shall be considered to be a tax described in section 275(a)(6).

(g) REPORTING REQUIREMENT.—Not later than the date determined by the Secretary of the Treasury following the end of any calendar year, the Secretary of Health and Human Services, the Secretary of Veterans Affairs, and the Secretary of Defense shall report to the Secretary of the Treasury, in such manner as the Secretary of the Treasury prescribes, the total branded prescription drug sales for each covered entity with respect to each specified government program under such Secretary's jurisdiction using the following methodology:

(1) MEDICARE PART D PROGRAM.—The Secretary of Health and Human Services shall report, for each covered entity and for each branded prescription drug of the covered entity covered by the Medicare Part D program, the product of—

(A) the per-unit ingredient cost, as reported to the Secretary of Health and Human Services by prescription drug plans and Medicare Advantage prescription drug plans, minus any per-unit rebate, discount, or other price

1 concession provided by the covered entity, as re-
2 ported to the Secretary of Health and Human
3 Services by the prescription drug plans and
4 Medicare Advantage prescription drug plans,
5 and
6 (B) the number of units of the branded
7 prescription drug paid for under the Medicare
8 Part D program.
9 (2) MEDICARE PART B PROGRAM.—The Sec-
10 retary of Health and Human Services shall report,
11 for each covered entity and for each branded pre-
12 scription drug of the covered entity covered by the
13 Medicare Part B program under section 1862(a) of
14 the Social Security Act, the product of—
15 (A) the per-unit average sales price (as de-
16 fined in section 1847A(c) of the Social Security
17 Act) or the per-unit Part B payment rate for
18 a separately paid branded prescription drug
19 without a reported average sales price, and
20 (B) the number of units of the branded
21 prescription drug paid for under the Medicare
22 Part B program.
23 The Centers for Medicare and Medicaid Services
24 shall establish a process for determining the units
25 and the allocated price for purposes of this section

for those branded prescription drugs that are not separately payable or for which National Drug Codes are not reported.

(3) MEDICAID PROGRAM.—The Secretary of Health and Human Services shall report, for each covered entity and for each branded prescription drug of the covered entity covered under the Medicaid program, the product of—

(A) the per-unit ingredient cost paid to pharmacies by States for the branded prescription drug dispensed to Medicaid beneficiaries, minus any per-unit rebate paid by the covered entity under section 1927 of the Social Security Act and any State supplemental rebate, and

(B) the number of units of the branded prescription drug paid for under the Medicaid program.

(4) DEPARTMENT OF VETERANS AFFAIRS PROGRAMS.—The Secretary of Veterans Affairs shall report, for each covered entity and for each branded prescription drug of the covered entity the total amount paid for each such branded prescription drug procured by the Department of Veterans Affairs for its beneficiaries.

(5) DEPARTMENT OF DEFENSE PROGRAMS AND TRICARE.—The Secretary of Defense shall report, for each covered entity and for each branded prescription drug of the covered entity, the sum of—

(A) the total amount paid for each such branded prescription drug procured by the Department of Defense for its beneficiaries, and

(B) for each such branded prescription drug dispensed under the TRICARE retail pharmacy program, the product of—

(i) the per-unit ingredient cost, minus any per-unit rebate paid by the covered entity, and

(ii) the number of units of the branded prescription drug dispensed under such program.

(h) SECRETARY.—For purposes of this section, the term ''Secretary'' includes the Secretary's delegate.

(i) GUIDANCE.—The Secretary of the Treasury shall publish guidance necessary to carry out the purposes of this section.

(j) APPLICATION OF SECTION.—This section shall apply to any branded prescription drug sales after December 31, 2008.

(k) CONFORMING AMENDMENT.—Section 1841(a) of the Social Security Act is amended by inserting ''or section 9008(c) of the Patient Protection and Affordable Care Act of 2009'' after ''this part''.

SEC. 9009. IMPOSITION OF ANNUAL FEE ON MEDICAL DEVICE MANUFACTURERS AND IMPORTERS.

(a) IMPOSITION OF FEE.—

(1) IN GENERAL.—Each covered entity engaged in the business of manufacturing or importing medical devices shall pay to the Secretary not later than the annual payment date of each calendar year beginning after 2009 a fee in an amount determined under subsection (b).

(2) ANNUAL PAYMENT DATE.—For purposes of this section, the term ''annual payment date'' means with respect to any calendar year the date determined by the Secretary, but in no event later than September 30 of such calendar year.

(b) DETERMINATION OF FEE AMOUNT.—

(1) IN GENERAL.—With respect to each covered entity, the fee under this section for any calendar year shall be equal to an amount that bears the same ratio to $2,000,000,000 as—

(A) the covered entity's gross receipts from medical device sales taken into account during the preceding calendar year, bear to

(B) the aggregate gross receipts of all covered entities from medical device sales taken into account during such preceding calendar year.

(2) GROSS RECEIPTS FROM SALES TAKEN INTO ACCOUNT.—For purposes of paragraph (1), the gross receipts from medical device sales taken into account during any calendar year with respect to any covered entity shall be determined in accordance with the following table:

With respect to a covered entity's aggregate gross receipts from medical device sales during the calendar year that are:	The percentage of gross receipts taken into account is:
Not more than $5,000,000	0 percent
More than $5,000,000 but not more than $25,000,000.	50 percent
More than $25,000,000	100 percent.

(3) SECRETARIAL DETERMINATION.—The Secretary shall calculate the amount of each covered entity's fee for any calendar year under paragraph (1). In calculating such amount, the Secretary shall determine such covered entity's gross receipts from medical device sales on the basis of reports submitted by the covered entity under subsection (f)

and through the use of any other source of information available to the Secretary.

(c) COVERED ENTITY.—

(1) IN GENERAL.—For purposes of this section, the term ''covered entity'' means any manufacturer or importer with gross receipts from medical device sales.

(2) CONTROLLED GROUPS.—

(A) IN GENERAL.—For purposes of this subsection, all persons treated as a single employer under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 or subsection (m) or (o) of section 414 of such Code shall be treated as a single covered entity.

(B) INCLUSION OF FOREIGN CORPORATIONS.—For purposes of subparagraph (A), in applying subsections (a) and (b) of section 52 of such Code to this section, section 1563 of such Code shall be applied without regard to subsection (b)(2)(C) thereof.

(d) MEDICAL DEVICE SALES.—For purposes of this section—

(1) IN GENERAL.—The term ''medical device sales'' means sales for use in the United States of

any medical device, other than the sales of a medical device that—

(A) has been classified in class II under section 513 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360c) and is primarily sold to consumers at retail for not more than $100 per unit, or

(B) has been classified in class I under such section.

(2) UNITED STATES.—For purposes of paragraph (1), the term ''United States'' means the several States, the District of Columbia, the Commonwealth of Puerto Rico, and the possessions of the United States.

(3) MEDICAL DEVICE.—For purposes of paragraph (1), the term ''medical device'' means any device (as defined in section 201(h) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(h))) intended for humans.

(e) TAX TREATMENT OF FEES.—The fees imposed by this section—

(1) for purposes of subtitle F of the Internal Revenue Code of 1986, shall be treated as excise taxes with respect to which only civil actions for re-

fund under procedures of such subtitle shall apply, and

(2) for purposes of section 275 of such Code, shall be considered to be a tax described in section 275(a)(6).

(f) REPORTING REQUIREMENT.—

(1) IN GENERAL.—Not later than the date determined by the Secretary following the end of any calendar year, each covered entity shall report to the Secretary, in such manner as the Secretary prescribes, the gross receipts from medical device sales of such covered entity during such calendar year.

(2) PENALTY FOR FAILURE TO REPORT.—

(A) IN GENERAL.—In the case of any failure to make a report containing the information required by paragraph (1) on the date prescribed therefor (determined with regard to any extension of time for filing), unless it is shown that such failure is due to reasonable cause, there shall be paid by the covered entity failing to file such report, an amount equal to—

(i) $10,000, plus

(ii) the lesser of—

(I) an amount equal to $1,000, multiplied by the number of days during which such failure continues, or

(II) the amount of the fee imposed by this section for which such report was required.

(B) TREATMENT OF PENALTY.—The penalty imposed under subparagraph (A)—

(i) shall be treated as a penalty for purposes of subtitle F of the Internal Revenue Code of 1986,

(ii) shall be paid on notice and demand by the Secretary and in the same manner as tax under such Code, and

(iii) with respect to which only civil actions for refund under procedures of such subtitle F shall apply.

(g) SECRETARY.—For purposes of this section, the term ''Secretary'' means the Secretary of the Treasury or the Secretary's delegate.

(h) GUIDANCE.—The Secretary shall publish guidance necessary to carry out the purposes of this section, including identification of medical devices described in subsection (d)(1)(A) and with respect to the treatment of gross receipts from sales of medical devices to another cov-

1 ered entity or to another entity by reason of the applica-
2 tion of subsection (c)(2).
3 (i) APPLICATION OF SECTION.—This section shall
4 apply to any medical device sales after December 31,
5 2008.

6 **SEC. 9010. IMPOSITION OF ANNUAL FEE ON HEALTH INSUR-**
7 **ANCE PROVIDERS.**

8 (a) IMPOSITION OF FEE.—
9 (1) IN GENERAL.—Each covered entity engaged
10 in the business of providing health insurance shall
11 pay to the Secretary not later than the annual pay-
12 ment date of each calendar year beginning after
13 2009 a fee in an amount determined under sub-
14 section (b).
15 (2) ANNUAL PAYMENT DATE.—For purposes of
16 this section, the term ''annual payment date'' means
17 with respect to any calendar year the date deter-
18 mined by the Secretary, but in no event later than
19 September 30 of such calendar year.
20 (b) DETERMINATION OF FEE AMOUNT.—
21 (1) IN GENERAL.—With respect to each covered
22 entity, the fee under this section for any calendar
23 year shall be equal to an amount that bears the
24 same ratio to $6,700,000,000 as—
25 (A) the sum of—

(i) the covered entity's net premiums written with respect to health insurance for any United States health risk that are taken into account during the preceding calendar year, plus

(ii) 200 percent of the covered entity's third party administration agreement fees that are taken into account during the preceding calendar year, bears to

(B) the sum of—

(i) the aggregate net premiums written with respect to such health insurance of all covered entities that are taken into account during such preceding calendar year, plus

(ii) 200 percent of the aggregate third party administration agreement fees of all covered entities that are taken into account during such preceding calendar year.

(2) AMOUNTS TAKEN INTO ACCOUNT.—For purposes of paragraph (1)—

(A) NET PREMIUMS WRITTEN.—The net premiums written with respect to health insurance for any United States health risk that are taken into account during any calendar year

with respect to any covered entity shall be determined in accordance with the following table:

With respect to a covered entity's net premiums written during the calendar year that are:	The percentage of net premiums written that are taken into account is:
Not more than $25,000,000	0 percent
More than $25,000,000 but not more than $50,000,000.	50 percent
More than $50,000,000	100 percent.

(B) THIRD PARTY ADMINISTRATION AGREEMENT FEES.—The third party administration agreement fees that are taken into account during any calendar year with respect to any covered entity shall be determined in accordance with the following table:

With respect to a covered entity's third party administration agreement fees during the calendar year that are:	The percentage of third party administration agreement fees that are taken into account is:
Not more than $5,000,000	0 percent
More than $5,000,000 but not more than $10,000,000.	50 percent
More than $10,000,000	100 percent.

(3) SECRETARIAL DETERMINATION.—The Secretary shall calculate the amount of each covered entity's fee for any calendar year under paragraph (1). In calculating such amount, the Secretary shall determine such covered entity's net premiums written with respect to any United States health risk and third party administration agreement fees on the

basis of reports submitted by the covered entity under subsection (g) and through the use of any other source of information available to the Secretary.

(c) COVERED ENTITY.—

(1) IN GENERAL.—For purposes of this section, the term ''covered entity'' means any entity which provides health insurance for any United States health risk.

(2) EXCLUSION.—Such term does not include—

(A) any employer to the extent that such employer self-insures its employees' health risks, or

(B) any governmental entity (except to the extent such an entity provides health insurance coverage through the community health insurance option under section 1323).

(3) CONTROLLED GROUPS.—

(A) IN GENERAL.—For purposes of this subsection, all persons treated as a single employer under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 or subsection (m) or (o) of section 414 of such Code shall be treated as a single covered entity (or employer for purposes of paragraph (2)).

(B) INCLUSION OF FOREIGN CORPORATIONS.—For purposes of subparagraph (A), in applying subsections (a) and (b) of section 52 of such Code to this section, section 1563 of such Code shall be applied without regard to subsection (b)(2)(C) thereof.

(d) UNITED STATES HEALTH RISK.—For purposes of this section, the term ''United States health risk'' means the health risk of any individual who is—

(1) a United States citizen,

(2) a resident of the United States (within the meaning of section 7701(b)(1)(A) of the Internal Revenue Code of 1986), or

(3) located in the United States, with respect to the period such individual is so located.

(e) THIRD PARTY ADMINISTRATION AGREEMENT FEES.—For purposes of this section, the term ''third party administration agreement fees'' means, with respect to any covered entity, amounts received from an employer which are in excess of payments made by such covered entity for health benefits under an arrangement under which such employer self-insures the United States health risk of its employees.

(f) TAX TREATMENT OF FEES.—The fees imposed by this section—

(1) for purposes of subtitle F of the Internal Revenue Code of 1986, shall be treated as excise taxes with respect to which only civil actions for refund under procedures of such subtitle shall apply, and

(2) for purposes of section 275 of such Code shall be considered to be a tax described in section 275(a)(6).

(g) REPORTING REQUIREMENT.—

(1) IN GENERAL.—Not later than the date determined by the Secretary following the end of any calendar year, each covered entity shall report to the Secretary, in such manner as the Secretary prescribes, the covered entity's net premiums written with respect to health insurance for any United States health risk and third party administration agreement fees for such calendar year.

(2) PENALTY FOR FAILURE TO REPORT.—

(A) IN GENERAL.—In the case of any failure to make a report containing the information required by paragraph (1) on the date prescribed therefor (determined with regard to any extension of time for filing), unless it is shown that such failure is due to reasonable cause,

there shall be paid by the covered entity failing to file such report, an amount equal to—

(i) $10,000, plus

(ii) the lesser of—

(I) an amount equal to $1,000, multiplied by the number of days during which such failure continues, or

(II) the amount of the fee imposed by this section for which such report was required.

(B) TREATMENT OF PENALTY.—The penalty imposed under subparagraph (A)—

(i) shall be treated as a penalty for purposes of subtitle F of the Internal Revenue Code of 1986,

(ii) shall be paid on notice and demand by the Secretary and in the same manner as tax under such Code, and

(iii) with respect to which only civil actions for refund under procedures of such subtitle F shall apply.

(h) ADDITIONAL DEFINITIONS.—For purposes of this section—

(1) SECRETARY.—The term ''Secretary'' means the Secretary of the Treasury or the Secretary's delegate.

(2) UNITED STATES.—The term ''United States'' means the several States, the District of Columbia, the Commonwealth of Puerto Rico, and the possessions of the United States.

(3) HEALTH INSURANCE.—The term ''health insurance'' shall not include insurance for long-term care or disability.

(i) GUIDANCE.—The Secretary shall publish guidance necessary to carry out the purposes of this section.

(j) APPLICATION OF SECTION.—This section shall apply to any net premiums written after December 31, 2008, with respect to health insurance for any United States health risk, and any third party administration agreement fees received after such date.

SEC. 9011. STUDY AND REPORT OF EFFECT ON VETERANS HEALTH CARE.

(a) IN GENERAL.—The Secretary of Veterans Affairs shall conduct a study on the effect (if any) of the provisions of sections 9008, 9009, and 9010 on—

(1) the cost of medical care provided to veterans, and

(2) veterans' access to medical devices and branded prescription drugs.

(b) REPORT.—The Secretary of Veterans Affairs shall report the results of the study under subsection (a) to the Committee on Ways and Means of the House of Representatives and to the Committee on Finance of the Senate not later than December 31, 2012.

SEC. 9012. ELIMINATION OF DEDUCTION FOR EXPENSES ALLOCABLE TO MEDICARE PART D SUBSIDY.

(a) IN GENERAL.—Section 139A of the Internal Revenue Code of 1986 is amended by striking the second sentence.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2010.

SEC. 9013. MODIFICATION OF ITEMIZED DEDUCTION FOR MEDICAL EXPENSES.

(a) IN GENERAL.—Subsection (a) of section 213 of the Internal Revenue Code of 1986 is amended by striking ''7.5 percent'' and inserting ''10 percent''.

(b) TEMPORARY WAIVER OF INCREASE FOR CERTAIN SENIORS.—Section 213 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

"(f) SPECIAL RULE FOR 2013, 2014, 2015, AND 2016.—In the case of any taxable year beginning after December 31, 2012, and ending before January 1, 2017, subsection (a) shall be applied with respect to a taxpayer by substituting '7.5 percent' for '10 percent' if such taxpayer or such taxpayer's spouse has attained age 65 before the close of such taxable year.".

(c) CONFORMING AMENDMENT.—Section 56(b)(1)(B) of the Internal Revenue Code of 1986 is amended by striking "by substituting '10 percent' for '7.5 percent'" and inserting "without regard to subsection (f) of such section".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2012.

SEC. 9014. LIMITATION ON EXCESSIVE REMUNERATION PAID BY CERTAIN HEALTH INSURANCE PROVIDERS.

(a) IN GENERAL.—Section 162(m) of the Internal Revenue Code of 1986 is amended by adding at the end the following new subparagraph:

"(6) SPECIAL RULE FOR APPLICATION TO CERTAIN HEALTH INSURANCE PROVIDERS.—

"(A) IN GENERAL.—No deduction shall be allowed under this chapter—

"(i) in the case of applicable individual remuneration which is for any disqualified taxable year beginning after December 31, 2012, and which is attributable to services performed by an applicable individual during such taxable year, to the extent that the amount of such remuneration exceeds $500,000, or

"(ii) in the case of deferred deduction remuneration for any taxable year beginning after December 31, 2012, which is attributable to services performed by an applicable individual during any disqualified taxable year beginning after December 31, 2009, to the extent that the amount of such remuneration exceeds $500,000 reduced (but not below zero) by the sum of—

"(I) the applicable individual remuneration for such disqualified taxable year, plus

"(II) the portion of the deferred deduction remuneration for such services which was taken into account under this clause in a preceding tax-

able year (or which would have been taken into account under this clause in a preceding taxable year if this clause were applied by substituting 'December 31, 2009' for 'December 31, 2012' in the matter preceding subclause (I)).

''(B) DISQUALIFIED TAXABLE YEAR.—For purposes of this paragraph, the term 'disqualified taxable year' means, with respect to any employer, any taxable year for which such employer is a covered health insurance provider.

''(C) COVERED HEALTH INSURANCE PROVIDER.—For purposes of this paragraph—

''(i) IN GENERAL.—The term 'covered health insurance provider' means—

''(I) with respect to taxable years beginning after December 31, 2009, and before January 1, 2013, any employer which is a health insurance issuer (as defined in section 9832(b)(2)) and which receives premiums from providing health insurance coverage (as defined in section 9832(b)(1)), and

"(II) with respect to taxable years beginning after December 31, 2012, any employer which is a health insurance issuer (as defined in section 9832(b)(2)) and with respect to which not less than 25 percent of the gross premiums received from providing health insurance coverage (as defined in section 9832(b)(1)) is from minimum essential coverage (as defined in section 5000A(f)).

"(ii) AGGREGATION RULES.—Two or more persons who are treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as a single employer, except that in applying section 1563(a) for purposes of any such subsection, paragraphs (2) and (3) thereof shall be disregarded.

"(D) APPLICABLE INDIVIDUAL REMUNERATION.—For purposes of this paragraph, the term 'applicable individual remuneration' means, with respect to any applicable individual for any disqualified taxable year, the aggregate amount allowable as a deduction under this

chapter for such taxable year (determined without regard to this subsection) for remuneration (as defined in paragraph (4) without regard to subparagraphs (B), (C), and (D) thereof) for services performed by such individual (whether or not during the taxable year). Such term shall not include any deferred deduction remuneration with respect to services performed during the disqualified taxable year.

"(E) DEFERRED DEDUCTION REMUNERATION.—For purposes of this paragraph, the term 'deferred deduction remuneration' means remuneration which would be applicable individual remuneration for services performed in a disqualified taxable year but for the fact that the deduction under this chapter (determined without regard to this paragraph) for such remuneration is allowable in a subsequent taxable year.

"(F) APPLICABLE INDIVIDUAL.—For purposes of this paragraph, the term 'applicable individual' means, with respect to any covered health insurance provider for any disqualified taxable year, any individual—

"(i) who is an officer, director, or employee in such taxable year, or

"(ii) who provides services for or on behalf of such covered health insurance provider during such taxable year.

"(G) COORDINATION.—Rules similar to the rules of subparagraphs (F) and (G) of paragraph (4) shall apply for purposes of this paragraph.

"(H) REGULATORY AUTHORITY.—The Secretary may prescribe such guidance, rules, or regulations as are necessary to carry out the purposes of this paragraph.".

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2009, with respect to services performed after such date.

SEC. 9015. ADDITIONAL HOSPITAL INSURANCE TAX ON HIGH-INCOME TAXPAYERS.

(a) FICA.—

(1) IN GENERAL.—Section 3101(b) of the Internal Revenue Code of 1986 is amended—

(A) by striking "In addition" and inserting the following:

"(1) IN GENERAL.—In addition",

(B) by striking ''the following percentages of the'' and inserting ''1.45 percent of the'',

(C) by striking ''(as defined in section 3121(b))—'' and all that follows and inserting ''(as defined in section 3121(b)).'', and

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

''(2) ADDITIONAL TAX.—In addition to the tax imposed by paragraph (1) and the preceding subsection, there is hereby imposed on every taxpayer (other than a corporation, estate, or trust) a tax equal to 0.5 percent of wages which are received with respect to employment (as defined in section 3121(b)) during any taxable year beginning after December 31, 2012, and which are in excess of—

''(A) in the case of a joint return, $250,000, and

''(B) in any other case, $200,000.''.

(2) COLLECTION OF TAX.—Section 3102 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

''(f) SPECIAL RULES FOR ADDITIONAL TAX.—

''(1) IN GENERAL.—In the case of any tax imposed by section 3101(b)(2), subsection (a) shall only apply to the extent to which the taxpayer re-

ceives wages from the employer in excess of $200,000, and the employer may disregard the amount of wages received by such taxpayer's spouse.

''(2) COLLECTION OF AMOUNTS NOT WITHHELD.—To the extent that the amount of any tax imposed by section 3101(b)(2) is not collected by the employer, such tax shall be paid by the employee.

''(3) TAX PAID BY RECIPIENT.—If an employer, in violation of this chapter, fails to deduct and withhold the tax imposed by section 3101(b)(2) and thereafter the tax is paid by the employee, the tax so required to be deducted and withheld shall not be collected from the employer, but this paragraph shall in no case relieve the employer from liability for any penalties or additions to tax otherwise applicable in respect of such failure to deduct and withhold.''.

(b) SECA.—

(1) IN GENERAL.—Section 1401(b) of the Internal Revenue Code of 1986 is amended—

(A) by striking ''In addition'' and inserting the following:

''(1) IN GENERAL.—In addition'', and

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

''(2) ADDITIONAL TAX.—

"(A) IN GENERAL.—In addition to the tax imposed by paragraph (1) and the preceding subsection, there is hereby imposed on every taxpayer (other than a corporation, estate, or trust) for each taxable year beginning after December 31, 2012, a tax equal to 0.5 percent of the self-employment income for such taxable year which is in excess of—

"(i) in the case of a joint return, $250,000, and

"(ii) in any other case, $200,000.

"(B) COORDINATION WITH FICA.—The amounts under clauses (i) and (ii) of subparagraph (A) shall be reduced (but not below zero) by the amount of wages taken into account in determining the tax imposed under section 3121(b)(2) with respect to the taxpayer.".

(2) NO DEDUCTION FOR ADDITIONAL TAX.—

(A) IN GENERAL.—Section 164(f) of such Code is amended by inserting "(other than the taxes imposed by section 1401(b)(2))" after "section 1401)".

(B) DEDUCTION FOR NET EARNINGS FROM SELF-EMPLOYMENT.—Subparagraph (B) of section 1402(a)(12) is amended by inserting "(de-

termined without regard to the rate imposed under paragraph (2) of section 1401(b))'' after ''for such year''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to remuneration received, and taxable years beginning, after December 31, 2012.

SEC. 9016. MODIFICATION OF SECTION 833 TREATMENT OF CERTAIN HEALTH ORGANIZATIONS.

(a) IN GENERAL.—Subsection (c) of section 833 of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:

''(5) NONAPPLICATION OF SECTION IN CASE OF LOW MEDICAL LOSS RATIO.—Notwithstanding the preceding paragraphs, this section shall not apply to any organization unless such organization's percentage of total premium revenue expended on reimbursement for clinical services provided to enrollees under its policies during such taxable year (as reported under section 2718 of the Public Health Service Act) is not less than 85 percent.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2009.

SEC. 9017. EXCISE TAX ON ELECTIVE COSMETIC MEDICAL PROCEDURES.

(a) IN GENERAL.—Subtitle D of the Internal Revenue Code of 1986, as amended by this Act, is amended by adding at the end the following new chapter:

"CHAPTER 49—ELECTIVE COSMETIC MEDICAL PROCEDURES

"Sec. 5000B. Imposition of tax on elective cosmetic medical procedures.

"SEC. 5000B. IMPOSITION OF TAX ON ELECTIVE COSMETIC MEDICAL PROCEDURES.

"(a) IN GENERAL.—There is hereby imposed on any cosmetic surgery and medical procedure a tax equal to 5 percent of the amount paid for such procedure (determined without regard to this section), whether paid by insurance or otherwise.

"(b) COSMETIC SURGERY AND MEDICAL PROCEDURE.—For purposes of this section, the term 'cosmetic surgery and medical procedure' means any cosmetic surgery (as defined in section 213(d)(9)(B)) or other similar procedure which—

"(1) is performed by a licensed medical professional, and

"(2) is not necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or disfiguring disease.

"(c) PAYMENT OF TAX.—

"(1) IN GENERAL.—The tax imposed by this section shall be paid by the individual on whom the procedure is performed.

"(2) COLLECTION.—Every person receiving a payment for procedures on which a tax is imposed under subsection (a) shall collect the amount of the tax from the individual on whom the procedure is performed and remit such tax quarterly to the Secretary at such time and in such manner as provided by the Secretary.

"(3) SECONDARY LIABILITY.—Where any tax imposed by subsection (a) is not paid at the time payments for cosmetic surgery and medical procedures are made, then to the extent that such tax is not collected, such tax shall be paid by the person who performs the procedure.".

(b) CLERICAL AMENDMENT.—The table of chapters for subtitle D of the Internal Revenue Code of 1986, as amended by this Act, is amended by inserting after the item relating to chapter 48 the following new item:

"CHAPTER 49—ELECTIVE COSMETIC MEDICAL PROCEDURES".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to procedures performed on or after January 1, 2010.

Subtitle B—Other Provisions

SEC. 9021. EXCLUSION OF HEALTH BENEFITS PROVIDED BY INDIAN TRIBAL GOVERNMENTS.

(a) IN GENERAL.—Part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after section 139C the following new section:

"SEC. 139D. INDIAN HEALTH CARE BENEFITS.

''(a) GENERAL RULE.—Except as otherwise provided in this section, gross income does not include the value of any qualified Indian health care benefit.

''(b) QUALIFIED INDIAN HEALTH CARE BENEFIT.—For purposes of this section, the term 'qualified Indian health care benefit' means—

''(1) any health service or benefit provided or purchased, directly or indirectly, by the Indian Health Service through a grant to or a contract or compact with an Indian tribe or tribal organization, or through a third-party program funded by the Indian Health Service,

''(2) medical care provided or purchased by, or amounts to reimburse for such medical care provided by, an Indian tribe or tribal organization for, or to, a member of an Indian tribe, including a spouse or dependent of such a member,

1 ''(3) coverage under accident or health insur-
2 ance (or an arrangement having the effect of acci-
3 dent or health insurance), or an accident or health
4 plan, provided by an Indian tribe or tribal organiza-
5 tion for medical care to a member of an Indian
6 tribe, include a spouse or dependent of such a mem-
7 ber, and
8 ''(4) any other medical care provided by an In-
9 dian tribe or tribal organization that supplements,
10 replaces, or substitutes for a program or service re-
11 lating to medical care provided by the Federal gov-
12 ernment to Indian tribes or members of such a tribe.
13 ''(c) DEFINITIONS.—For purposes of this section—
14 ''(1) INDIAN TRIBE.—The term 'Indian tribe'
15 has the meaning given such term by section
16 45A(c)(6).
17 ''(2) TRIBAL ORGANIZATION.—The term 'tribal
18 organization' has the meaning given such term by
19 section 4(l) of the Indian Self-Determination and
20 Education Assistance Act.
21 ''(3) MEDICAL CARE.—The term 'medical care'
22 has the same meaning as when used in section 213.
23 ''(4) ACCIDENT OR HEALTH INSURANCE; ACCI-
24 DENT OR HEALTH PLAN.—The terms 'accident or

health insurance' and 'accident or health plan' have the same meaning as when used in section 105.

"(5) DEPENDENT.—The term 'dependent' has the meaning given such term by section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof.

"(d) DENIAL OF DOUBLE BENEFIT.—Subsection (a) shall not apply to the amount of any qualified Indian health care benefit which is not includible in gross income of the beneficiary of such benefit under any other provision of this chapter, or to the amount of any such benefit for which a deduction is allowed to such beneficiary under any other provision of this chapter.".

(b) CLERICAL AMENDMENT.—The table of sections for part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after the item relating to section 139C the following new item:

"Sec. 139D. Indian health care benefits.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to benefits and coverage provided after the date of the enactment of this Act.

(d) NO INFERENCE.—Nothing in the amendments made by this section shall be construed to create an inference with respect to the exclusion from gross income of—

(1) benefits provided by an Indian tribe or tribal organization that are not within the scope of this section, and

(2) benefits provided prior to the date of the enactment of this Act.

SEC. 9022. ESTABLISHMENT OF SIMPLE CAFETERIA PLANS FOR SMALL BUSINESSES.

(a) IN GENERAL.—Section 125 of the Internal Revenue Code of 1986 (relating to cafeteria plans), as amended by this Act, is amended by redesignating subsections (j) and (k) as subsections (k) and (l), respectively, and by inserting after subsection (i) the following new subsection:

''(j) SIMPLE CAFETERIA PLANS FOR SMALL BUSINESSES.—

''(1) IN GENERAL.—An eligible employer maintaining a simple cafeteria plan with respect to which the requirements of this subsection are met for any year shall be treated as meeting any applicable nondiscrimination requirement during such year.

''(2) SIMPLE CAFETERIA PLAN.—For purposes of this subsection, the term 'simple cafeteria plan' means a cafeteria plan—

''(A) which is established and maintained by an eligible employer, and

"(B) with respect to which the contribution requirements of paragraph (3), and the eligibility and participation requirements of paragraph (4), are met.

"(3) CONTRIBUTION REQUIREMENTS.—

"(A) IN GENERAL.—The requirements of this paragraph are met if, under the plan the employer is required, without regard to whether a qualified employee makes any salary reduction contribution, to make a contribution to provide qualified benefits under the plan on behalf of each qualified employee in an amount equal to—

"(i) a uniform percentage (not less than 2 percent) of the employee's compensation for the plan year, or

"(ii) an amount which is not less than the lesser of—

"(I) 6 percent of the employee's compensation for the plan year, or

"(II) twice the amount of the salary reduction contributions of each qualified employee.

"(B) MATCHING CONTRIBUTIONS ON BEHALF OF HIGHLY COMPENSATED AND KEY EM-

PLOYEES.—The requirements of subparagraph (A)(ii) shall not be treated as met if, under the plan, the rate of contributions with respect to any salary reduction contribution of a highly compensated or key employee at any rate of contribution is greater than that with respect to an employee who is not a highly compensated or key employee.

"(C) ADDITIONAL CONTRIBUTIONS.—Subject to subparagraph (B), nothing in this paragraph shall be treated as prohibiting an employer from making contributions to provide qualified benefits under the plan in addition to contributions required under subparagraph (A).

"(D) DEFINITIONS.—For purposes of this paragraph—

"(i) SALARY REDUCTION CONTRIBUTION.—The term 'salary reduction contribution' means, with respect to a cafeteria plan, any amount which is contributed to the plan at the election of the employee and which is not includible in gross income by reason of this section.

"(ii) QUALIFIED EMPLOYEE.—The term 'qualified employee' means, with re-

spect to a cafeteria plan, any employee who is not a highly compensated or key employee and who is eligible to participate in the plan.

"(iii) HIGHLY COMPENSATED EMPLOYEE.—The term 'highly compensated employee' has the meaning given such term by section 414(q).

"(iv) KEY EMPLOYEE.—The term 'key employee' has the meaning given such term by section 416(i).

"(4) MINIMUM ELIGIBILITY AND PARTICIPATION REQUIREMENTS.—

"(A) IN GENERAL.—The requirements of this paragraph shall be treated as met with respect to any year if, under the plan—

"(i) all employees who had at least 1,000 hours of service for the preceding plan year are eligible to participate, and

"(ii) each employee eligible to participate in the plan may, subject to terms and conditions applicable to all participants, elect any benefit available under the plan.

"(B) CERTAIN EMPLOYEES MAY BE EXCLUDED.—For purposes of subparagraph

(A)(i), an employer may elect to exclude under the plan employees—

"(i) who have not attained the age of 21 before the close of a plan year,

"(ii) who have less than 1 year of service with the employer as of any day during the plan year,

"(iii) who are covered under an agreement which the Secretary of Labor finds to be a collective bargaining agreement if there is evidence that the benefits covered under the cafeteria plan were the subject of good faith bargaining between employee representatives and the employer, or

"(iv) who are described in section 410(b)(3)(C) (relating to nonresident aliens working outside the United States).

A plan may provide a shorter period of service or younger age for purposes of clause (i) or (ii).

"(5) ELIGIBLE EMPLOYER.—For purposes of this subsection—

"(A) IN GENERAL.—The term 'eligible employer' means, with respect to any year, any employer if such employer employed an average of 100 or fewer employees on business days

during either of the 2 preceding years. For purposes of this subparagraph, a year may only be taken into account if the employer was in existence throughout the year.

"(B) EMPLOYERS NOT IN EXISTENCE DURING PRECEDING YEAR.—If an employer was not in existence throughout the preceding year, the determination under subparagraph (A) shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current year.

"(C) GROWING EMPLOYERS RETAIN TREATMENT AS SMALL EMPLOYER.—

"(i) IN GENERAL.—If—

"(I) an employer was an eligible employer for any year (a 'qualified year'), and

"(II) such employer establishes a simple cafeteria plan for its employees for such year,

then, notwithstanding the fact the employer fails to meet the requirements of subparagraph (A) for any subsequent year, such employer shall be treated as an eligible employer for such subsequent year with

respect to employees (whether or not employees during a qualified year) of any trade or business which was covered by the plan during any qualified year.

"(ii) EXCEPTION.—This subparagraph shall cease to apply if the employer employs an average of 200 or more employees on business days during any year preceding any such subsequent year.

"(D) SPECIAL RULES.—

"(i) PREDECESSORS.—Any reference in this paragraph to an employer shall include a reference to any predecessor of such employer.

"(ii) AGGREGATION RULES.—All persons treated as a single employer under subsection (a) or (b) of section 52, or subsection (n) or (o) of section 414, shall be treated as one person.

"(6) APPLICABLE NONDISCRIMINATION REQUIREMENT.—For purposes of this subsection, the term 'applicable nondiscrimination requirement' means any requirement under subsection (b) of this section, section 79(d), section 105(h), or paragraph (2), (3), (4), or (8) of section 129(d).

"(7) COMPENSATION.—The term 'compensation' has the meaning given such term by section 414(s).".

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to years beginning after December 31, 2010.

SEC. 9023. QUALIFYING THERAPEUTIC DISCOVERY PROJECT CREDIT.

(a) IN GENERAL.—Subpart E of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after section 48C the following new section:

"SEC. 48D. QUALIFYING THERAPEUTIC DISCOVERY PROJECT CREDIT.

"(a) IN GENERAL.—For purposes of section 46, the qualifying therapeutic discovery project credit for any taxable year is an amount equal to 50 percent of the qualified investment for such taxable year with respect to any qualifying therapeutic discovery project of an eligible taxpayer.

"(b) QUALIFIED INVESTMENT.—

"(1) IN GENERAL.—For purposes of subsection (a), the qualified investment for any taxable year is the aggregate amount of the costs paid or incurred in such taxable year for expenses necessary for and

1 directly related to the conduct of a qualifying thera-
2 peutic discovery project.
3 "(2) LIMITATION.—The amount which is treat-
4 ed as qualified investment for all taxable years with
5 respect to any qualifying therapeutic discovery
6 project shall not exceed the amount certified by the
7 Secretary as eligible for the credit under this sec-
8 tion.
9 "(3) EXCLUSIONS.—The qualified investment
10 for any taxable year with respect to any qualifying
11 therapeutic discovery project shall not take into ac-
12 count any cost—
13 "(A) for remuneration for an employee de-
14 scribed in section 162(m)(3),
15 "(B) for interest expenses,
16 "(C) for facility maintenance expenses,
17 "(D) which is identified as a service cost
18 under section 1.263A-1(e)(4) of title 26, Code
19 of Federal Regulations, or
20 "(E) for any other expense as determined
21 by the Secretary as appropriate to carry out the
22 purposes of this section.
23 "(4) CERTAIN PROGRESS EXPENDITURE RULES
24 MADE APPLICABLE.—In the case of costs described
25 in paragraph (1) that are paid for property of a

character subject to an allowance for depreciation, rules similar to the rules of subsections (c)(4) and (d) of section 46 (as in effect on the day before the date of the enactment of the Revenue Reconciliation Act of 1990) shall apply for purposes of this section.

"(5) APPLICATION OF SUBSECTION.—An investment shall be considered a qualified investment under this subsection only if such investment is made in a taxable year beginning in 2009 or 2010.

"(c) DEFINITIONS.—

"(1) QUALIFYING THERAPEUTIC DISCOVERY PROJECT.—The term 'qualifying therapeutic discovery project' means a project which is designed—

"(A) to treat or prevent diseases or conditions by conducting pre-clinical activities, clinical trials, and clinical studies, or carrying out research protocols, for the purpose of securing approval of a product under section 505(b) of the Federal Food, Drug, and Cosmetic Act or section 351(a) of the Public Health Service Act,

"(B) to diagnose diseases or conditions or to determine molecular factors related to diseases or conditions by developing molecular diagnostics to guide therapeutic decisions, or

"(C) to develop a product, process, or technology to further the delivery or administration of therapeutics.

"(2) ELIGIBLE TAXPAYER.—

"(A) IN GENERAL.—The term 'eligible taxpayer' means a taxpayer which employs not more than 250 employees in all businesses of the taxpayer at the time of the submission of the application under subsection (d)(2).

"(B) AGGREGATION RULES.—All persons treated as a single employer under subsection (a) or (b) of section 52, or subsection (m) or (o) of section 414, shall be so treated for purposes of this paragraph.

"(3) FACILITY MAINTENANCE EXPENSES.—The term 'facility maintenance expenses' means costs paid or incurred to maintain a facility, including—

"(A) mortgage or rent payments,

"(B) insurance payments,

"(C) utility and maintenance costs, and

"(D) costs of employment of maintenance personnel.

"(d) QUALIFYING THERAPEUTIC DISCOVERY PROJECT PROGRAM.—

"(1) ESTABLISHMENT.—

"(A) IN GENERAL.—Not later than 60 days after the date of the enactment of this section, the Secretary, in consultation with the Secretary of Health and Human Services, shall establish a qualifying therapeutic discovery project program to consider and award certifications for qualified investments eligible for credits under this section to qualifying therapeutic discovery project sponsors.

"(B) LIMITATION.—The total amount of credits that may be allocated under the program shall not exceed $1,000,000,000 for the 2-year period beginning with 2009.

"(2) CERTIFICATION.—

"(A) APPLICATION PERIOD.—Each applicant for certification under this paragraph shall submit an application containing such information as the Secretary may require during the period beginning on the date the Secretary establishes the program under paragraph (1).

"(B) TIME FOR REVIEW OF APPLICATIONS.—The Secretary shall take action to approve or deny any application under subparagraph (A) within 30 days of the submission of such application.

"(C) MULTI-YEAR APPLICATIONS.—An application for certification under subparagraph (A) may include a request for an allocation of credits for more than 1 of the years described in paragraph (1)(B).

"(3) SELECTION CRITERIA.—In determining the qualifying therapeutic discovery projects with respect to which qualified investments may be certified under this section, the Secretary—

"(A) shall take into consideration only those projects that show reasonable potential—

"(i) to result in new therapies—

"(I) to treat areas of unmet medical need, or

"(II) to prevent, detect, or treat chronic or acute diseases and conditions,

"(ii) to reduce long-term health care costs in the United States, or

"(iii) to significantly advance the goal of curing cancer within the 30-year period beginning on the date the Secretary establishes the program under paragraph (1), and

"(B) shall take into consideration which projects have the greatest potential—

"(i) to create and sustain (directly or indirectly) high quality, high-paying jobs in the United States, and

"(ii) to advance United States competitiveness in the fields of life, biological, and medical sciences.

"(4) DISCLOSURE OF ALLOCATIONS.—The Secretary shall, upon making a certification under this subsection, publicly disclose the identity of the applicant and the amount of the credit with respect to such applicant.

"(e) SPECIAL RULES.—

"(1) BASIS ADJUSTMENT.—For purposes of this subtitle, if a credit is allowed under this section for an expenditure related to property of a character subject to an allowance for depreciation, the basis of such property shall be reduced by the amount of such credit.

"(2) DENIAL OF DOUBLE BENEFIT.—

"(A) BONUS DEPRECIATION.—A credit shall not be allowed under this section for any investment for which bonus depreciation is al-

lowed under section 168(k), 1400L(b)(1), or 1400N(d)(1).

"(B) DEDUCTIONS.—No deduction under this subtitle shall be allowed for the portion of the expenses otherwise allowable as a deduction taken into account in determining the credit under this section for the taxable year which is equal to the amount of the credit determined for such taxable year under subsection (a) attributable to such portion. This subparagraph shall not apply to expenses related to property of a character subject to an allowance for depreciation the basis of which is reduced under paragraph (1), or which are described in section 280C(g).

"(C) CREDIT FOR RESEARCH ACTIVITIES.—

"(i) IN GENERAL.—Except as provided in clause (ii), any expenses taken into account under this section for a taxable year shall not be taken into account for purposes of determining the credit allowable under section 41 or 45C for such taxable year.

"(ii) EXPENSES INCLUDED IN DETERMINING BASE PERIOD RESEARCH EXPENSES.—Any expenses for any taxable year which are qualified research expenses (within the meaning of section 41(b)) shall be taken into account in determining base period research expenses for purposes of applying section 41 to subsequent taxable years.

"(f) COORDINATION WITH DEPARTMENT OF TREASURY GRANTS.—In the case of any investment with respect to which the Secretary makes a grant under section 9023(e) of the Patient Protection and Affordable Care Act of 2009—

"(1) DENIAL OF CREDIT.—No credit shall be determined under this section with respect to such investment for the taxable year in which such grant is made or any subsequent taxable year.

"(2) RECAPTURE OF CREDITS FOR PROGRESS EXPENDITURES MADE BEFORE GRANT.—If a credit was determined under this section with respect to such investment for any taxable year ending before such grant is made—

"(A) the tax imposed under subtitle A on the taxpayer for the taxable year in which such

grant is made shall be increased by so much of such credit as was allowed under section 38,

"(B) the general business carryforwards under section 39 shall be adjusted so as to recapture the portion of such credit which was not so allowed, and

"(C) the amount of such grant shall be determined without regard to any reduction in the basis of any property of a character subject to an allowance for depreciation by reason of such credit.

"(3) TREATMENT OF GRANTS.—Any such grant shall not be includible in the gross income of the taxpayer.".

(b) INCLUSION AS PART OF INVESTMENT CREDIT.—Section 46 of the Internal Revenue Code of 1986 is amended—

(1) by adding a comma at the end of paragraph (2),

(2) by striking the period at the end of paragraph (5) and inserting ", and", and

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

"(6) the qualifying therapeutic discovery project credit.".

(c) CONFORMING AMENDMENTS.—

(1) Section 49(a)(1)(C) of the Internal Revenue Code of 1986 is amended—

(A) by striking ''and'' at the end of clause (iv),

(B) by striking the period at the end of clause (v) and inserting '', and'', and

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

''(vi) the basis of any property to which paragraph (1) of section 48D(e) applies which is part of a qualifying therapeutic discovery project under such section 48D.''.

(2) Section 280C of such Code is amended by adding at the end the following new subsection:

''(g) QUALIFYING THERAPEUTIC DISCOVERY PROJECT CREDIT.—

''(1) IN GENERAL.—No deduction shall be allowed for that portion of the qualified investment (as defined in section 48D(b)) otherwise allowable as a deduction for the taxable year which—

''(A) would be qualified research expenses (as defined in section 41(b)), basic research expenses (as defined in section 41(e)(2)), or quali-

fied clinical testing expenses (as defined in section 45C(b)) if the credit under section 41 or section 45C were allowed with respect to such expenses for such taxable year, and

"(B) is equal to the amount of the credit determined for such taxable year under section 48D(a), reduced by—

"(i) the amount disallowed as a deduction by reason of section 48D(e)(2)(B), and

"(ii) the amount of any basis reduction under section 48D(e)(1).

"(2) SIMILAR RULE WHERE TAXPAYER CAPITALIZES RATHER THAN DEDUCTS EXPENSES.—In the case of expenses described in paragraph (1)(A) taken into account in determining the credit under section 48D for the taxable year, if—

"(A) the amount of the portion of the credit determined under such section with respect to such expenses, exceeds

"(B) the amount allowable as a deduction for such taxable year for such expenses (determined without regard to paragraph (1)),

the amount chargeable to capital account for the taxable year for such expenses shall be reduced by the amount of such excess.

"(3) CONTROLLED GROUPS.—Paragraph (3) of subsection (b) shall apply for purposes of this subsection.".

(d) CLERICAL AMENDMENT.—The table of sections for subpart E of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after the item relating to section 48C the following new item:

"Sec. 48D. Qualifying therapeutic discovery project credit.".

(e) GRANTS FOR QUALIFIED INVESTMENTS IN THERAPEUTIC DISCOVERY PROJECTS IN LIEU OF TAX CREDITS.—

(1) IN GENERAL.—Upon application, the Secretary of the Treasury shall, subject to the requirements of this subsection, provide a grant to each person who makes a qualified investment in a qualifying therapeutic discovery project in the amount of 50 percent of such investment. No grant shall be made under this subsection with respect to any investment unless such investment is made during a taxable year beginning in 2009 or 2010.

(2) APPLICATION.—

(A) IN GENERAL.—At the stated election of the applicant, an application for certification under section 48D(d)(2) of the Internal Revenue Code of 1986 for a credit under such section for the taxable year of the applicant which begins in 2009 shall be considered to be an application for a grant under paragraph (1) for such taxable year.

(B) TAXABLE YEARS BEGINNING IN 2010.—An application for a grant under paragraph (1) for a taxable year beginning in 2010 shall be submitted—

(i) not earlier than the day after the last day of such taxable year, and

(ii) not later than the due date (including extensions) for filing the return of tax for such taxable year.

(C) INFORMATION TO BE SUBMITTED.—An application for a grant under paragraph (1) shall include such information and be in such form as the Secretary may require to state the amount of the credit allowable (but for the receipt of a grant under this subsection) under section 48D for the taxable year for the quali-

fied investment with respect to which such application is made.

(3) TIME FOR PAYMENT OF GRANT.—

(A) IN GENERAL.—The Secretary of the Treasury shall make payment of the amount of any grant under paragraph (1) during the 30-day period beginning on the later of—

(i) the date of the application for such grant, or

(ii) the date the qualified investment for which the grant is being made is made.

(B) REGULATIONS.—In the case of investments of an ongoing nature, the Secretary shall issue regulations to determine the date on which a qualified investment shall be deemed to have been made for purposes of this paragraph.

(4) QUALIFIED INVESTMENT.—For purposes of this subsection, the term ''qualified investment'' means a qualified investment that is certified under section 48D(d) of the Internal Revenue Code of 1986 for purposes of the credit under such section 48D.

(5) APPLICATION OF CERTAIN RULES.—

(A) IN GENERAL.—In making grants under this subsection, the Secretary of the

Treasury shall apply rules similar to the rules of section 50 of the Internal Revenue Code of 1986. In applying such rules, any increase in tax under chapter 1 of such Code by reason of an investment ceasing to be a qualified investment shall be imposed on the person to whom the grant was made.

(B) SPECIAL RULES.—

(i) RECAPTURE OF EXCESSIVE GRANT AMOUNTS.—If the amount of a grant made under this subsection exceeds the amount allowable as a grant under this subsection, such excess shall be recaptured under subparagraph (A) as if the investment to which such excess portion of the grant relates had ceased to be a qualified investment immediately after such grant was made.

(ii) GRANT INFORMATION NOT TREATED AS RETURN INFORMATION.—In no event shall the amount of a grant made under paragraph (1), the identity of the person to whom such grant was made, or a description of the investment with respect to which such grant was made be

treated as return information for purposes of section 6103 of the Internal Revenue Code of 1986.

(6) EXCEPTION FOR CERTAIN NON-TAXPAYERS.—The Secretary of the Treasury shall not make any grant under this subsection to—

(A) any Federal, State, or local government (or any political subdivision, agency, or instrumentality thereof),

(B) any organization described in section 501(c) of the Internal Revenue Code of 1986 and exempt from tax under section 501(a) of such Code,

(C) any entity referred to in paragraph (4) of section 54(j) of such Code, or

(D) any partnership or other pass-thru entity any partner (or other holder of an equity or profits interest) of which is described in subparagraph (A), (B) or (C).

In the case of a partnership or other pass-thru entity described in subparagraph (D), partners and other holders of any equity or profits interest shall provide to such partnership or entity such information as the Secretary of the Treasury may require to carry out the purposes of this paragraph.

(7) SECRETARY.—Any reference in this subsection to the Secretary of the Treasury shall be treated as including the Secretary's delegate.

(8) OTHER TERMS.—Any term used in this subsection which is also used in section 48D of the Internal Revenue Code of 1986 shall have the same meaning for purposes of this subsection as when used in such section.

(9) DENIAL OF DOUBLE BENEFIT.—No credit shall be allowed under section 46(6) of the Internal Revenue Code of 1986 by reason of section 48D of such Code for any investment for which a grant is awarded under this subsection.

(10) APPROPRIATIONS.—There is hereby appropriated to the Secretary of the Treasury such sums as may be necessary to carry out this subsection.

(11) TERMINATION.—The Secretary of the Treasury shall not make any grant to any person under this subsection unless the application of such person for such grant is received before January 1, 2013.

(f) EFFECTIVE DATE.—The amendments made by subsections (a) through (d) of this section shall apply to amounts paid or incurred after December 31, 2008, in taxable years beginning after such date.

Amendment No. 2786

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