The enrolled bill and joint resolution were subsequently signed by the Acting President pro tempore (Mr. CASEY).

ADDITIONAL COSPONSORS

S. 565

At the request of Mr. DURBIN, the name of the Senator from California (Mrs. BOXER) was added as a cosponsor of S. 565, a bill to amend title XVIII of the Social Security Act to provide continued entitlement to coverage for immunosuppressive drugs furnished to beneficiaries under the Medicare Program that have received a kidney transplant and whose entitlement to coverage would otherwise expire, and for other purposes.

AMENDMENT NO. 3065

At the request of Mr. CARDIN, the name of the Senator from West Virginia (Mr. ROCKEFELLER) was added as a cosponsor of amendment No. 3065 intended to be proposed to H.R. 3590, a bill 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.

AMENDMENT NO. 3076

At the request of Mr. DURBIN, the name of the Senator from Massachusetts (Mr. KERRY) was added as a cosponsor of amendment No. 3076 intended to be proposed to H.R. 3590, a bill 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.

AMENDMENT NO. 3077

At the request of Mr. DURBIN, the name of the Senator from Illinois (Mr. BURRIS) was added as a cosponsor of amendment No. 3077 intended to be proposed to H.R. 3590, a bill 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.

AMENDMENTS SUBMITTED AND PROPOSED

SA 3276. Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) proposed an amendment to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill 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.

SA 3277. Mr. REID proposed an amendment to amendment SA 3276 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra.

SA 3278. Mr. REID proposed an amendment to the bill H.R. 3590, supra.

SA 3279. Mr. REID proposed an amendment to amendment SA 3278 proposed by Mr. REID to the bill H.R. 3590, supra.

SA 3280. Mr. REID proposed an amendment to the bill H.R. 3590, supra.

SA 3281. Mr. REID proposed an amendment to amendment SA 3280 proposed by Mr. REID to the bill H.R. 3590, supra.

SA 3282. Mr. REID proposed an amendment to amendment SA 3281 proposed by Mr. REID to the amendment SA 3280 proposed by Mr. REID to the bill H.R. 3590, supra.

SA 3283. Mr. COBURN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3276. Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) proposed an amendment to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill 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; which was ordered to lie on the table; as follows:

On page 2074, strike lines 22 through 25, and insert the following:

(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.

TITLE X—STRENGTHENING QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS

Subtitle A—Provisions Relating to Title I

SEC. 10101. AMENDMENTS TO SUBTITLE A.

(a) Section 2711 of the Public Health Service Act, as added by section 1001(5) of this Act, is amended to read as follows:

"SEC. 2711. NO LIFETIME OR ANNUAL LIMITS.

"(a) PROHIBITION.—

"(1) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage may not establish—

"(A) lifetime limits on the dollar value of benefits for any participant or beneficiary; or

"(B) except as provided in paragraph (2), annual limits on the dollar value of benefits for any participant or beneficiary.

"(2) ANNUAL LIMITS PRIOR TO 2014.—With respect to plan years beginning prior to January 1, 2014, a group health plan and a health insurance issuer offering group or individual health insurance coverage may only establish a restricted annual limit on the dollar value of benefits for any participant or beneficiary with respect to the scope of benefits that are essential health benefits under section 1302(b) of the Patient Protection and Affordable Care Act, as determined by the Secretary. In defining the term 'restricted annual limit' for purposes of the preceding sentence, the Secretary shall ensure that access to needed services is made available with a minimal impact on premiums.

"(b) PER BENEFICIARY LIMITS.—Subsection (a) shall not be construed to prevent a group health plan or health insurance coverage from placing annual or lifetime per beneficiary limits on specific covered benefits that are not essential health benefits under section 1302(b) of the Patient Protection and Affordable Care Act, to the extent that such limits are otherwise permitted under Federal or State law.".

(b) Section 2715(a) of the Public Health Service Act, as added by section 1001(5) of this Act, is amended by striking "and providing to enrollees" and inserting "and providing to applicants, enrollees, and policyholders or certificate holders".

(c) Subpart II of part A of title XXVII of the Public Health Service Act, as added by section 1001(5), is amended by inserting after section 2715, the following:

"SEC. 2715A. PROVISION OF ADDITIONAL INFORMATION.

"A group health plan and a health insurance issuer offering group or individual health insurance coverage shall comply with the provisions of section 1311(e)(3) of the Patient Protection and Affordable Care Act, except that a plan or coverage that is not offered through an Exchange shall only be required to submit the information required to the Secretary and the State insurance commissioner, and make such information available to the public.".

(d) Section 2716 of the Public Health Service Act, as added by section 1001(5) of this Act, is amended to read as follows:

"SEC. 2716. PROHIBITION ON DISCRIMINATION IN FAVOR OF HIGHLY COMPENSATED INDIVIDUALS.

"(a) IN GENERAL.—A group health plan (other than a self-insured plan) shall satisfy the requirements of section 105(h)(2) of the Internal Revenue Code of 1986 (relating to prohibition on discrimination in favor of highly compensated individuals).

"(b) RULES AND DEFINITIONS.—For purposes of this section—

"(1) CERTAIN RULES TO APPLY.—Rules similar to the rules contained in paragraphs (3), (4), and (8) of section 105(h) of such Code shall apply.

"(2) HIGHLY COMPENSATED INDIVIDUAL.—The term 'highly compensated individual' has the meaning given such term by section 105(h)(5) of such Code.".

(e) Section 2717 of the Public Health Service Act, as added by section 1001(5) of this Act, is amended—

(1) by redesignating subsections (c) and (d) as subsections (d) and (e), respectively; and

(2) by inserting after subsection (b), the following:

"(c) PROTECTION OF SECOND AMENDMENT GUN RIGHTS.—

"(1) WELLNESS AND PREVENTION PROGRAMS.—A wellness and health promotion activity implemented under subsection (a)(1)(D) may not require the disclosure or collection of any information relating to—

"(A) the presence or storage of a lawfully-possessed firearm or ammunition in the residence or on the property of an individual; or

"(B) the lawful use, possession, or storage of a firearm or ammunition by an individual.

"(2) LIMITATION ON DATA COLLECTION.—None of the authorities provided to the Secretary under the Patient Protection and Affordable Care Act or an amendment made by that Act shall be construed to authorize or may be used for the collection of any information relating to—

"(A) the lawful ownership or possession of a firearm or ammunition;

"(B) the lawful use of a firearm or ammunition; or

"(C) the lawful storage of a firearm or ammunition.

"(3) LIMITATION ON DATABASES OR DATA BANKS.—None of the authorities provided to the Secretary under the Patient Protection and Affordable Care Act or an amendment made by that Act shall be construed to authorize or may be used to maintain records of individual ownership or possession of a firearm or ammunition.

"(4) LIMITATION ON DETERMINATION OF PREMIUM RATES OR ELIGIBILITY FOR HEALTH INSURANCE.—A premium rate may not be increased, health insurance coverage may not be denied, and a discount, rebate, or reward offered for participation in a wellness program may not be reduced or withheld under

any health benefit plan issued pursuant to or in accordance with the Patient Protection and Affordable Care Act or an amendment made by that Act on the basis of, or on reliance upon—

''(A) the lawful ownership or possession of a firearm or ammunition; or

''(B) the lawful use or storage of a firearm or ammunition.

''(5) LIMITATION ON DATA COLLECTION REQUIREMENTS FOR INDIVIDUALS.—No individual shall be required to disclose any information under any data collection activity authorized under the Patient Protection and Affordable Care Act or an amendment made by that Act relating to—

''(A) the lawful ownership or possession of a firearm or ammunition; or

''(B) the lawful use, possession, or storage of a firearm or ammunition.''.

(f) Section 2718 of the Public Health Service Act, as added by section 1001(5), is amended to read as follows:

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

''(a) CLEAR ACCOUNTING FOR COSTS.—A health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, with respect to each plan year, submit to the Secretary a report concerning the ratio of the incurred loss (or incurred claims) plus the loss adjustment expense (or change in contract reserves) to earned premiums. Such report shall include the percentage of total premium revenue, after accounting for collections or receipts for risk adjustment and risk corridors and payments of reinsurance, that such coverage expends—

''(1) on reimbursement for clinical services provided to enrollees under such coverage;

''(2) for activities that improve health care quality; and

''(3) on all other non-claims costs, including an explanation of the nature of such costs, and excluding Federal and State taxes and licensing or regulatory fees.

The Secretary shall make reports received under this section available to the public on the Internet website of the Department of Health and Human Services.

''(b) ENSURING THAT CONSUMERS RECEIVE VALUE FOR THEIR PREMIUM PAYMENTS.—

''(1) REQUIREMENT TO PROVIDE VALUE FOR PREMIUM PAYMENTS.—

''(A) REQUIREMENT.—Beginning not later than January 1, 2011, a health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, with respect to each plan year, provide an annual rebate to each enrollee under such coverage, on a pro rata basis, if the ratio of the amount of premium revenue expended by the issuer on costs described in paragraphs (1) and (2) of subsection (a) to the total amount of premium revenue (excluding Federal and State taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 1341, 1342, and 1343 of the Patient Protection and Affordable Care Act) for the plan year (except as provided in subparagraph (B)(ii)), is less than—

''(i) with respect to a health insurance issuer offering coverage in the large group market, 85 percent, or such higher percentage as a State may by regulation determine; or

''(ii) with respect to a health insurance issuer offering coverage in the small group market or in the individual market, 80 percent, or such higher percentage as a State may by regulation determine, except that the Secretary may adjust such percentage with respect to a State if the Secretary determines that the application of such 80 percent may destabilize the individual market in such State.

''(B) REBATE AMOUNT.—

''(i) CALCULATION OF AMOUNT.—The total amount of an annual rebate required under this paragraph shall be in an amount equal to the product of—

''(I) the amount by which the percentage described in clause (i) or (ii) of subparagraph (A) exceeds the ratio described in such subparagraph; and

''(II) the total amount of premium revenue (excluding Federal and State taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 1341, 1342, and 1343 of the Patient Protection and Affordable Care Act) for such plan year.

''(ii) CALCULATION BASED ON AVERAGE RATIO.—Beginning on January 1, 2014, the determination made under subparagraph (A) for the year involved shall be based on the averages of the premiums expended on the costs described in such subparagraph and total premium revenue for each of the previous 3 years for the plan.

''(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) ENFORCEMENT.—The Secretary shall promulgate regulations for enforcing the provisions of this section and may provide for appropriate penalties.

''(c) DEFINITIONS.—Not later than December 31, 2010, and subject to the certification of the Secretary, the National Association of Insurance Commissioners shall establish uniform definitions of the activities reported under subsection (a) and standardized methodologies for calculating measures of such activities, including definitions of which activities, and in what regard such activities, constitute activities described in subsection (a)(2). Such methodologies shall be designed to take into account the special circumstances of smaller plans, different types of plans, and newer plans.

''(d) ADJUSTMENTS.—The Secretary may adjust the rates described in subsection (b) if the Secretary determines appropriate on account of the volatility of the individual market due to the establishment of State Exchanges.

''(e) 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.''.

(g) Section 2719 of the Public Health Service Act, as added by section 1001(4) of this Act, is amended to read as follows:

''SEC. 2719. APPEALS PROCESS.

''(a) INTERNAL CLAIMS APPEALS.—

''(1) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall implement an effective appeals process for appeals of coverage determinations and claims, under which the plan or issuer shall, at a minimum—

''(A) have in effect an internal claims appeal process;

''(B) provide notice to enrollees, in a culturally and linguistically appropriate manner, of available internal and external appeals processes, and the availability of any applicable office of health insurance consumer assistance or ombudsman established under section 2793 to assist such enrollees with the appeals processes; and

''(C) allow an enrollee to review their file, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process.

''(2) ESTABLISHED PROCESSES.—To comply with paragraph (1)—

''(A) a group health plan and a health insurance issuer offering group health coverage shall provide an internal claims and appeals process that initially incorporates the claims and appeals procedures (including urgent claims) set forth at section 2560.503-1 of title 29, Code of Federal Regulations, as published on November 21, 2000 (65 Fed. Reg. 70256), and shall update such process in accordance with any standards established by the Secretary of Labor for such plans and issuers; and

''(B) a health insurance issuer offering individual health coverage, and any other issuer not subject to subparagraph (A), shall provide an internal claims and appeals process that initially incorporates the claims and appeals procedures set forth under applicable law (as in existence on the date of enactment of this section), and shall update such process in accordance with any standards established by the Secretary of Health and Human Services for such issuers.

''(b) EXTERNAL REVIEW.—A group health plan and a health insurance issuer offering group or individual health insurance coverage—

''(1) shall comply with the applicable State external review process for such 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; or

''(2) shall implement an effective external review process that meets minimum standards established by the Secretary through guidance and that is similar to the process described under paragraph (1)—

''(A) if the applicable State has not established an external review process that meets the requirements of paragraph (1); or

''(B) if the plan is a self-insured plan that is not subject to State insurance regulation (including a State law that establishes an external review process described in paragraph (1)).

''(c) SECRETARY AUTHORITY.—The Secretary may deem the external review process of a group health plan or health insurance issuer, in operation as of the date of enactment of this section, to be in compliance with the applicable process established under subsection (b), as determined appropriate by the Secretary.''.

(h) Subpart II of part A of title XVIII of the Public Health Service Act, as added by section 1001(5) of this Act, is amended by inserting after section 2719 the following:

''SEC. 2719A. PATIENT PROTECTIONS.

''(a) CHOICE OF HEALTH CARE PROFESSIONAL.—If a group health plan, or a health insurance issuer offering group or individual health insurance coverage, requires or provides for designation by a participant, beneficiary, or enrollee of a participating primary care provider, then the plan or issuer shall permit each participant, beneficiary, and enrollee to designate any participating primary care provider who is available to accept such individual.

''(b) COVERAGE OF EMERGENCY SERVICES.—

''(1) IN GENERAL.—If a group health plan, or a health insurance issuer offering group or individual health insurance issuer, provides

or covers any benefits with respect to services in an emergency department of a hospital, the plan or issuer shall cover emergency services (as defined in paragraph (2)(B))—

''(A) without the need for any prior authorization determination;

''(B) whether the health care provider furnishing such services is a participating provider with respect to such services;

''(C) in a manner so that, if such services are provided to a participant, beneficiary, or enrollee—

''(i) by a nonparticipating health care provider with or without prior authorization; or

''(ii)(I) such services will be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the plan for the providing of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the plan; and

''(II) if such services are provided out-of-network, the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is the same requirement that would apply if such services were provided in-network;

''(D) without regard to any other term or condition of such coverage (other than exclusion or coordination of benefits, or an affiliation or waiting period, permitted under section 2701 of this Act, section 701 of the Employee Retirement Income Security Act of 1974, or section 9801 of the Internal Revenue Code of 1986, and other than applicable cost-sharing).

''(2) DEFINITIONS.—In this subsection:

''(A) EMERGENCY MEDICAL CONDITION.—The term 'emergency medical condition' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.

''(B) EMERGENCY SERVICES.—The term 'emergency services' means, with respect to an emergency medical condition—

''(i) a medical screening examination (as required under section 1867 of the Social Security Act) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and

''(ii) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under section 1867 of such Act to stabilize the patient.

''(C) STABILIZE.—The term 'to stabilize', with respect to an emergency medical condition (as defined in subparagraph (A)), has the meaning give in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

''(c) ACCESS TO PEDIATRIC CARE.—

''(1) PEDIATRIC CARE.—In the case of a person who has a child who is a participant, beneficiary, or enrollee under a group health plan, or health insurance coverage offered by a health insurance issuer in the group or individual market, if the plan or issuer requires or provides for the designation of a participating primary care provider for the child, the plan or issuer shall permit such person to designate a physician (allopathic or osteopathic) who specializes in pediatrics as the child's primary care provider if such provider participates in the network of the plan or issuer.

''(2) CONSTRUCTION.—Nothing in paragraph (1) shall be construed to waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of pediatric care.

''(d) PATIENT ACCESS TO OBSTETRICAL AND GYNECOLOGICAL CARE.—

''(1) GENERAL RIGHTS.—

''(A) DIRECT ACCESS.—A group health plan, or health insurance issuer offering group or individual health insurance coverage, described in paragraph (2) may not require authorization or referral by the plan, issuer, or any person (including a primary care provider described in paragraph (2)(B))) in the case of a female participant, beneficiary, or enrollee who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology. Such professional shall agree to otherwise adhere to such plan's or issuer's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan or issuer.

''(B) OBSTETRICAL AND GYNECOLOGICAL CARE.—A group health plan or health insurance issuer described in paragraph (2) shall treat the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services, pursuant to the direct access described under subparagraph (A), by a participating health care professional who specializes in obstetrics or gynecology as the authorization of the primary care provider.

''(2) APPLICATION OF PARAGRAPH.—A group health plan, or health insurance issuer offering group or individual health insurance coverage, described in this paragraph is a group health plan or coverage that—

''(A) provides coverage for obstetric or gynecologic care; and

''(B) requires the designation by a participant, beneficiary, or enrollee of a participating primary care provider.

''(3) CONSTRUCTION.—Nothing in paragraph (1) shall be construed to—

''(A) waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of obstetrical or gynecological care; or

''(B) preclude the group health plan or health insurance issuer involved from requiring that the obstetrical or gynecological provider notify the primary care health care professional or the plan or issuer of treatment decisions.''.

(i) Section 2794 of the Public Health Service Act, as added by section 1003 of this Act, is amended—

(1) in subsection (c)(1)—

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

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

(C) by adding at the end the following:

''(C) in establishing centers (consistent with subsection (d)) at academic or other nonprofit institutions to collect medical reimbursement information from health insurance issuers, to analyze and organize such information, and to make such information available to such issuers, health care providers, health researchers, health care policy makers, and the general public.''; and

(2) by adding at the end the following:

''(d) MEDICAL REIMBURSEMENT DATA CENTERS.—

''(1) FUNCTIONS.—A center established under subsection (c)(1)(C) shall—

''(A) develop fee schedules and other database tools that fairly and accurately reflect market rates for medical services and the geographic differences in those rates;

''(B) use the best available statistical methods and data processing technology to develop such fee schedules and other database tools;

''(C) regularly update such fee schedules and other database tools to reflect changes in charges for medical services;

''(D) make health care cost information readily available to the public through an Internet website that allows consumers to understand the amounts that health care providers in their area charge for particular medical services; and

''(E) regularly publish information concerning the statistical methodologies used by the center to analyze health charge data and make such data available to researchers and policy makers.

''(2) CONFLICTS OF INTEREST.—A center established under subsection (c)(1)(C) shall adopt by-laws that ensures that the center (and all members of the governing board of the center) is independent and free from all conflicts of interest. Such by-laws shall ensure that the center is not controlled or influenced by, and does not have any corporate relation to, any individual or entity that may make or receive payments for health care services based on the center's analysis of health care costs.

''(3) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to permit a center established under subsection (c)(1)(C) to compel health insurance issuers to provide data to the center.''.

SEC. 10102. AMENDMENTS TO SUBTITLE B.

(a) Section 1102(a)(2)(B) of this Act is amended—

(1) in the matter preceding clause (i), by striking ''group health benefits plan'' and inserting ''group benefits plan providing health benefits''; and

(2) in clause (i)(I), by inserting ''or any agency or instrumentality of any of the foregoing'' before the closed parenthetical.

(b) Section 1103(a) of this Act is amended—

(1) in paragraph (1), by inserting '', or small business in,'' after ''residents of any''; and

(2) by striking paragraph (2) and inserting the following:

''(2) CONNECTING TO AFFORDABLE COVERAGE.—An Internet website established under paragraph (1) shall, to the extent practicable, provide ways for residents of, and small businesses in, any State to receive information on at least the following coverage options:

''(A) Health insurance coverage offered by health insurance issuers, other than coverage that provides reimbursement only for the treatment or mitigation of—

''(i) a single disease or condition; or

''(ii) an unreasonably limited set of diseases or conditions (as determined by the Secretary).

''(B) Medicaid coverage under title XIX of the Social Security Act.

''(C) Coverage under title XXI of the Social 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.

''(F) Coverage within the small group market for small businesses and their employees, including reinsurance for early retirees under section 1102, tax credits available under section 45R of the Internal Revenue Code of 1986 (as added by section 1421), and other information specifically for small businesses regarding affordable health care options.''.

SEC. 10103. AMENDMENTS TO SUBTITLE C.

(a) Section 2701(a)(5) of the Public Health Service Act, as added by section 1201(4) of

this Act, is amended by inserting ''(other than self-insured group health plans offered in such market)'' after ''such market''.

(b) Section 2708 of the Public Health Service Act, as added by section 1201(4) of this Act, is amended by striking ''or individual''.

(c) Subpart I of part A of title XXVII of the Public Health Service Act, as added by section 1201(4) of this Act, is amended by inserting after section 2708, the following:

''SEC. 2709. COVERAGE FOR INDIVIDUALS PARTICIPATING IN APPROVED CLINICAL TRIALS.

''(a) COVERAGE.—

''(1) IN GENERAL.—If a group health plan or a health insurance issuer offering group or individual health insurance coverage provides coverage to a qualified individual, then such plan or issuer—

''(A) may not deny the individual participation in the clinical trial referred to in subsection (b)(2);

''(B) subject to subsection (c), may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and

''(C) may not discriminate against the individual on the basis of the individual's participation in such trial.

''(2) ROUTINE PATIENT COSTS.—

''(A) INCLUSION.—For purposes of paragraph (1)(B), subject to subparagraph (B), routine patient costs include all items and services consistent with the coverage provided in the plan (or coverage) that is typically covered for a qualified individual who is not enrolled in a clinical trial.

''(B) EXCLUSION.—For purposes of paragraph (1)(B), routine patient costs does not include—

''(i) the investigational item, device, or service, itself;

''(ii) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or

''(iii) a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

''(3) USE OF IN-NETWORK PROVIDERS.—If one or more participating providers is participating in a clinical trial, nothing in paragraph (1) shall be construed as preventing a plan or issuer from requiring that a qualified individual participate in the trial through such a participating provider if the provider will accept the individual as a participant in the trial.

''(4) USE OF OUT-OF-NETWORK.—Notwithstanding paragraph (3), paragraph (1) shall apply to a qualified individual participating in an approved clinical trial that is conducted outside the State in which the qualified individual resides.

''(b) QUALIFIED INDIVIDUAL DEFINED.—For purposes of subsection (a), the term 'qualified individual' means an individual who is a participant or beneficiary in a health plan or with coverage described in subsection (a)(1) and who meets the following conditions:

''(1) The individual is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition.

''(2) Either—

''(A) the referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1); or

''(B) the participant or beneficiary provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1).

''(c) LIMITATIONS ON COVERAGE.—This section shall not be construed to require a group health plan, or a health insurance issuer offering group or individual health insurance coverage, to provide benefits for routine patient care services provided outside of the plan's (or coverage's) health care provider network unless out-of-network benefits are otherwise provided under the plan (or coverage).

''(d) APPROVED CLINICAL TRIAL DEFINED.—

''(1) IN GENERAL.—In this section, the term 'approved clinical trial' means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is described in any of the following subparagraphs:

''(A) FEDERALLY FUNDED TRIALS.—The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

''(i) The National Institutes of Health.

''(ii) The Centers for Disease Control and Prevention.

''(iii) The Agency for Health Care Research and Quality.

''(iv) The Centers for Medicare & Medicaid Services.

''(v) cooperative group or center of any of the entities described in clauses (i) through (iv) or the Department of Defense or the Department of Veterans Affairs.

''(vi) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

''(vii) Any of the following if the conditions described in paragraph (2) are met:

''(I) The Department of Veterans Affairs.

''(II) The Department of Defense.

''(III) The Department of Energy.

''(B) The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.

''(C) The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

''(2) CONDITIONS FOR DEPARTMENTS.—The conditions described in this paragraph, for a study or investigation conducted by a Department, are that the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines—

''(A) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and

''(B) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

''(e) LIFE-THREATENING CONDITION DEFINED.—In this section, the term 'life-threatening condition' means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

''(f) CONSTRUCTION.—Nothing in this section shall be construed to limit a plan's or issuer's coverage with respect to clinical trials.

''(g) APPLICATION TO FEHBP.—Notwithstanding any provision of chapter 89 of title 5, United States Code, this section shall apply to health plans offered under the program under such chapter.

''(h) PREEMPTION.—Notwithstanding any other provision of this Act, nothing in this section shall preempt State laws that require a clinical trials policy for State regulated health insurance plans that is in addition to the policy required under this section.''.

(d) Section 1251(a) of this Act is amended—

(1) in paragraph (2), by striking ''With'' and inserting ''Except as provided in paragraph (3), with''; and

(2) by adding at the end the following:

''(3) APPLICATION OF CERTAIN PROVISIONS.—The provisions of sections 2715 and 2718 of the Public Health Service Act (as added by subtitle A) shall apply to grandfathered health plans for plan years beginning on or after the date of enactment of this Act.''.

(e) Section 1253 of this Act is amended insert before the period the following: '', except that—

''(1) section 1251 shall take effect on the date of enactment of this Act; and

''(2) the provisions of section 2704 of the Public Health Service Act (as amended by section 1201), as they apply to enrollees who are under 19 years of age, shall become effective for plan years beginning on or after the date that is 6 months after the date of enactment of this Act.''.

(f) Subtitle C of title I of this Act is amended—

(1) by redesignating section 1253 as section 1255; and

(2) by inserting after section 1252, the following:

''SEC. 1253. ANNUAL REPORT ON SELF-INSURED PLANS.

''Not later than 1 year after the date of enactment of this Act, and annually thereafter, the Secretary of Labor shall prepare an aggregate annual report, using data collected from the Annual Return/Report of Employee Benefit Plan (Department of Labor Form 5500), that shall include general information on self-insured group health plans (including plan type, number of participants, benefits offered, funding arrangements, and benefit arrangements) as well as data from the financial filings of self-insured employers (including information on assets, liabilities, contributions, investments, and expenses). The Secretary shall submit such reports to the appropriate committees of Congress.

''SEC. 1254. STUDY OF LARGE GROUP MARKET.

''(a) IN GENERAL.—The Secretary of Health and Human Services shall conduct a study of the fully-insured and self-insured group health plan markets to—

''(1) compare the characteristics of employers (including industry, size, and other characteristics as determined appropriate by the Secretary), health plan benefits, financial solvency, capital reserve levels, and the risks of becoming insolvent; and

''(2) determine the extent to which new insurance market reforms are likely to cause adverse selection in the large group market or to encourage small and midsize employers to self-insure.

''(b) COLLECTION OF INFORMATION.—In conducting the study under subsection (a), the Secretary, in coordination with the Secretary of Labor, shall collect information and analyze—

''(1) the extent to which self-insured group health plans can offer less costly coverage and, if so, whether lower costs are due to more efficient plan administration and lower overhead or to the denial of claims and the offering very limited benefit packages;

''(2) claim denial rates, plan benefit fluctuations (to evaluate the extent that plans scale back health benefits during economic downturns), and the impact of the limited recourse options on consumers; and

''(3) any potential conflict of interest as it relates to the health care needs of self-insured enrollees and self-insured employer's financial contribution or profit margin, and the impact of such conflict on administration of the health plan.

''(c) REPORT.—Not later than 1 year after the date of enactment of this Act, the Secretary shall submit to the appropriate committees of Congress a report concerning the results of the study conducted under subsection (a).''.

SEC. 10104. AMENDMENTS TO SUBTITLE D.

(a) Section 1301(a) of this Act is amended by striking paragraph (2) and inserting the following:

''(2) INCLUSION OF CO-OP PLANS AND MULTI-STATE QUALIFIED HEALTH PLANS.—Any reference in this title to a qualified health plan shall be deemed to include a qualified health plan offered through the CO-OP program under section 1322, and a multi-State plan under section 1334, unless specifically provided for otherwise.

''(3) TREATMENT OF QUALIFIED DIRECT PRIMARY CARE MEDICAL HOME PLANS.—The Secretary of Health and Human Services shall permit a qualified health plan to provide coverage through a qualified direct primary care medical home plan that meets criteria established by the Secretary, so long as the qualified health plan meets all requirements that are otherwise applicable and the services covered by the medical home plan are coordinated with the entity offering the qualified health plan.

''(4) VARIATION BASED ON RATING AREA.—A qualified health plan, including a multi-State qualified health plan, may as appropriate vary premiums by rating area (as defined in section 2701(a)(2) of the Public Health Service Act).''.

(b) Section 1302 of this Act is amended—

(1) in subsection (d)(2)(B), by striking ''may issue'' and inserting ''shall issue''; and

(2) by adding at the end the following:

''(g) PAYMENTS TO FEDERALLY-QUALIFIED HEALTH CENTERS.—If any item or service covered by a qualified health plan is provided by a Federally-qualified health center (as defined in section 1905(l)(2)(B) of the Social Security Act (42 U.S.C. 1396d(l)(2)(B)) to an enrollee of the plan, the offeror of the plan shall pay to the center for the item or service an amount that is not less than the amount of payment that would have been paid to the center under section 1902(bb) of such Act (42 U.S.C. 1396a(bb)) for such item or service.''.

(c) Section 1303 of this Act is amended to read as follows:

''SEC. 1303. SPECIAL RULES.

''(a) STATE OPT-OUT OF ABORTION COVERAGE.—

''(1) IN GENERAL.—A State may elect to prohibit abortion coverage in qualified health plans offered through an Exchange in such State if such State enacts a law to provide for such prohibition.

''(2) TERMINATION OF OPT OUT.—A State may repeal a law described in paragraph (1) and provide for the offering of such services through the Exchange.

''(b) 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)—

''(i) nothing in this title (or any amendment made by this title), shall be construed to require a qualified health plan to provide coverage of services described in subparagraph (B)(i) or (B)(ii) as part of its essential health benefits for any plan year; and

''(ii) subject to subsection (a), the issuer of a qualified health plan shall determine whether or not the plan provides coverage of services described in subparagraph (B)(i) or (B)(ii) as part of such benefits for the plan year.

''(B) ABORTION SERVICES.—

''(i) ABORTIONS FOR WHICH PUBLIC FUNDING IS PROHIBITED.—The services described in this clause are abortions for which the expenditure of Federal funds appropriated for the Department of Health and Human Services is not permitted, based on the law as in effect as of the date that is 6 months before the beginning of the plan year involved.

''(ii) ABORTIONS FOR WHICH PUBLIC FUNDING IS ALLOWED.—The services described in this clause are abortions for which the expenditure of Federal funds appropriated for the Department of Health 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.

''(2) PROHIBITION ON THE USE OF FEDERAL FUNDS.—

''(A) IN GENERAL.—If a qualified health plan provides coverage of services described in paragraph (1)(B)(i), the issuer of the plan shall not use any amount attributable to any of the following for purposes of paying for such services:

''(i) The credit under section 36B of the Internal Revenue Code of 1986 (and the amount (if any) of the advance payment of the credit under section 1412 of the Patient Protection and Affordable Care Act).

''(ii) Any cost-sharing reduction under section 1402 of thePatient Protection and Affordable Care Act (and the amount (if any) of the advance payment of the reduction under section 1412 of the Patient Protection and Affordable Care Act).

''(B) ESTABLISHMENT OF ALLOCATION ACCOUNTS.—In the case of a plan to which subparagraph (A) applies, the issuer of the plan shall—

''(i) collect from each enrollee in the plan (without regard to the enrollee's age, sex, or family status) a separate payment for each of the following:

''(I) an amount equal to the portion of the premium to be paid directly by the enrollee for coverage under the plan of services other than services described in paragraph (1)(B)(i) (after reduction for credits and cost-sharing reductions described in subparagraph (A)); and

''(II) an amount equal to the actuarial value of the coverage of services described in paragraph (1)(B)(i), and

''(ii) shall deposit all such separate payments into separate allocation accounts as provided in subparagraph (C).

In the case of an enrollee whose premium for coverage under the plan is paid through employee payroll deposit, the separate payments required under this subparagraph shall each be paid by a separate deposit.

''(C) SEGREGATION OF FUNDS.—

''(i) IN GENERAL.—The issuer of a plan to which subparagraph (A) applies shall establish allocation accounts described in clause (ii) for enrollees receiving amounts described in subparagraph (A).

''(ii) ALLOCATION ACCOUNTS.—The issuer of a plan to which subparagraph (A) applies shall deposit—

''(I) all payments described in subparagraph (B)(i)(I) into a separate account that consists solely of such payments and that is used exclusively to pay for services other than services described in paragraph (1)(B)(i); and

''(II) all payments described in subparagraph (B)(i)(II) into a separate account that consists solely of such payments and that is used exclusively to pay for services described in paragraph (1)(B)(i).

''(D) ACTUARIAL VALUE.—

''(i) IN GENERAL.—The issuer of a qualified health plan shall estimate the basic per enrollee, per month cost, determined on an average actuarial basis, for including coverage under the qualified health plan of the services described in paragraph (1)(B)(i).

''(ii) CONSIDERATIONS.—In making such estimate, the issuer—

''(I) may take into account the impact on overall costs of the inclusion of such coverage, but may not take into account any cost reduction estimated to result from such services, including prenatal care, delivery, or postnatal care;

''(II) shall estimate such costs as if such coverage were included for the entire population covered; and

''(III) may not estimate such a cost at less than $1 per enrollee, per month.

''(E) ENSURING COMPLIANCE WITH SEGREGATION REQUIREMENTS.—

''(i) IN GENERAL.—Subject to clause (ii), State health insurance commissioners shall ensure that health plans comply with the segregation requirements in this subsection through the segregation of plan funds 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.

''(ii) CLARIFICATION.—Nothing in clause (i) shall prohibit the right of an individual or health plan to appeal such action in courts of competent jurisdiction.

''(3) RULES RELATING TO NOTICE.—

''(A) NOTICE.—A qualified health plan that provides for coverage of the services described in paragraph (1)(B)(i) shall provide a notice to enrollees, only as part of the summary of benefits and coverage explanation, at the time of enrollment, of such coverage.

''(B) RULES RELATING TO PAYMENTS.—The notice described in subparagraph (A), any advertising used by the issuer with respect to the plan, any information provided by the Exchange, and any other information specified by the Secretary shall provide information only with respect to the total amount of the combined payments for services described in paragraph (1)(B)(i) and other services covered by the plan.

''(4) NO DISCRIMINATION ON BASIS OF PROVISION OF ABORTION.—No qualified health plan offered through an Exchange may discriminate against any individual health care provider or health care facility because of its unwillingness to provide, pay for, provide coverage of, or refer for abortions

''(c) APPLICATION OF STATE AND FEDERAL LAWS REGARDING ABORTION.—

''(1) NO PREEMPTION OF STATE LAWS REGARDING ABORTION.—Nothing in this Act shall be construed to preempt or otherwise have any effect on State laws regarding the prohibition of (or requirement of) coverage, funding, or procedural requirements on abortions, including parental notification or consent for the performance of an abortion on a 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.

''(d) 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').''.

(d) Section 1304 of this Act is amended by adding at the end the following:

''(e) EDUCATED HEALTH CARE CONSUMERS.—The term 'educated health care consumer' means an individual who is knowledgeable about the health care system, and has background or experience in making informed decisions regarding health, medical, and scientific matters.''.

(e) Section 1311(d) of this Act is amended—

(1) in paragraph (3)(B), by striking clause (ii) and inserting the following:

''(ii) STATE MUST ASSUME COST.—A State shall make payments—

''(I) to an individual enrolled in a qualified health plan offered in such State; or

''(II) on behalf of an individual described in subclause (I) directly to the qualified health plan in which such individual is enrolled;

to defray the cost of any additional benefits described in clause (i).''; and

(2) in paragraph (6)(A), by inserting ''educated'' before ''health care''.

(f) Section 1311(e) of this Act is amended—

(1) in paragraph (2), by striking ''may'' in the second sentence and inserting ''shall''; and

(2) by adding at the end the following:

''(3) TRANSPARENCY IN COVERAGE.—

''(A) IN GENERAL.—The Exchange shall require health plans seeking certification as qualified health plans to submit to the Exchange, the Secretary, the State insurance commissioner, and make available to the public, accurate and timely disclosure of the following information:

''(i) Claims payment policies and practices.

''(ii) Periodic financial disclosures.

''(iii) Data on enrollment.

''(iv) Data on disenrollment.

''(v) Data on the number of claims that are denied.

''(vi) Data on rating practices.

''(vii) Information on cost-sharing and payments with respect to any out-of-network coverage.

''(viii) Information on enrollee and participant rights under this title.

''(ix) Other information as determined appropriate by the Secretary.

''(B) USE OF PLAIN LANGUAGE.—The information required to be submitted under subparagraph (A) shall be provided in plain language. The term 'plain language' means language that the intended audience, including individuals with limited English proficiency, can readily understand and use because that language is concise, well-organized, and follows other best practices of plain language writing. The Secretary and the Secretary of Labor shall jointly develop and issue guidance on best practices of plain language writing.

''(C) COST SHARING TRANSPARENCY.—The Exchange shall require health plans seeking certification as qualified health plans to permit individuals to learn the amount of cost-sharing (including deductibles, copayments, and coinsurance) under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider in a timely manner upon the request of the individual. At a minimum, such information shall be made available to such individual through an Internet website and such other means for individuals without access to the Internet.

''(D) GROUP HEALTH PLANS.—The Secretary of Labor shall update and harmonize the Secretary's rules concerning the accurate and timely disclosure to participants by group health plans of plan disclosure, plan terms and conditions, and periodic financial disclosure with the standards established by the Secretary under subparagraph (A).''.

(g) Section 1311(g)(1) of this Act is amended—

(1) in subparagraph (C), by striking ''; and'' and inserting a semicolon;

(2) in subparagraph (D), by striking the period and inserting ''; and''; and

(3) by adding at the end the following:

''(E) the implementation of activities to reduce health and health care disparities, including through the use of language services, community outreach, and cultural competency trainings.''.

(h) Section 1311(i)(2)((B) of this Act is amended by striking ''small business development centers'' and inserting ''resource partners of the Small Business Administration''.

(i) Section 1312 of this Act is amended—

(1) in subsection (a)(1), by inserting ''and for which such individual is eligible'' before the period;

(2) in subsection (e)—

(A) in paragraph (1), by inserting ''and employers'' after ''enroll individuals''; and

(B) by striking the flush sentence at the end; and

(3) in subsection (f)(1)(A)(ii), by striking the parenthetical.

(j)(1) Subparagraph (B) of section 1313(a)(6) of this Act is hereby deemed null, void, and of no effect.

(2) Section 3730(e) of title 31, United States Code, is amended by striking paragraph (4) and inserting the following:

''(4)(A) The court shall dismiss an action or claim under this section, unless opposed by the Government, if substantially the same allegations or transactions as alleged in the action or claim were publicly disclosed—

''(i) in a Federal criminal, civil, or administrative hearing in which the Government or its agent is a party;

''(ii) in a congressional, Government Accountability Office, or other Federal report, hearing, audit, or investigation; or

''(iii) from the news media,

unless the action is brought by the Attorney General or the person bringing the action is an original source of the information.

''(B) For purposes of this paragraph, ''original source'' means an individual who either (i) prior to a public disclosure under subsection (e)(4)(a), has voluntarily disclosed to the Government the information on which allegations or transactions in a claim are based, or (2) who has knowledge that is independent of and materially adds to the publicly disclosed allegations or transactions, and who has voluntarily provided the information to the Government before filing an action under this section.''.

(k) Section 1313(b) of this Act is amended—

(1) in paragraph (3), by striking ''and'' at the end;

(2) by redesignating paragraph (4) as paragraph (5); and

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

''(4) a survey of the cost and affordability of health care insurance provided under the Exchanges for owners and employees of small business concerns (as defined under section 3 of the Small Business Act (15 U.S.C. 632)), including data on enrollees in Exchanges and individuals purchasing health insurance coverage outside of Exchanges; and''.

(l) Section 1322(b) of this Act is amended—

(1) by redesignating paragraph (3) as paragraph (4); and

(2) by inserting after paragraph (2), the following:

''(3) REPAYMENT OF LOANS AND GRANTS.—Not later than July 1, 2013, and prior to awarding loans and grants under the CO-OP program, the Secretary shall promulgate regulations with respect to the repayment of such loans and grants in a manner that is consistent with State solvency regulations and other similar State laws that may apply. In promulgating such regulations, the Secretary shall provide that such loans shall be repaid within 5 years and such grants shall be repaid within 15 years, taking into consideration any appropriate State reserve requirements, solvency regulations, and requisite surplus note arrangements that must be constructed in a State to provide for such repayment prior to awarding such loans and grants.''.

(m) Part III of subtitle D of title I of this Act is amended by striking section 1323.

(n) Section 1324(a) of this Act is amended by striking '', a community health'' and all that follows through ''1333(b)'' and inserting '', or a multi-State qualified health plan under section 1334''.

(o) Section 1331 of this Act is amended—

(1) in subsection (d)(3)(A)(i), by striking ''85'' and inserting ''95''; and

(2) in subsection (e)(1)(B), by inserting before the semicolon the following: '', or, in the case of an alien lawfully present in the United States, whose income is not greater than 133 percent of the poverty line for the size of the family involved but who is not eligible for the Medicaid program under title XIX of the Social Security Act by reason of such alien status''.

(p) Section 1333 of this Act is amended by striking subsection (b).

(q) Part IV of subtitle D of title I of this Act is amended by adding at the end the following:

''SEC. 1334. MULTI-STATE PLANS.

''(a) OVERSIGHT BY THE OFFICE OF PERSONNEL MANAGEMENT.—

''(1) IN GENERAL.—The Director of the Office of Personnel Management (referred to in this section as the 'Director') shall enter into contracts with health insurance issuers (which may include a group of health insurance issuers affiliated either by common ownership and control or by the common use of a nationally licensed service mark), without regard to section 5 of title 41, United States Code, or other statutes requiring competitive bidding, to offer at least 2 multi-State qualified health plans through each Exchange in each State. Such plans shall provide individual, or in the case of small employers, group coverage.

''(2) TERMS.—Each contract entered into under paragraph (1) shall be for a uniform term of at least 1 year, but may be made automatically renewable from term to term in the absence of notice of termination by either party. In entering into such contracts, the Director shall ensure that health benefits coverage is provided in accordance with the types of coverage provided for under section 2701(a)(1)(A)(i) of the Public Health Service Act.

''(3) NON-PROFIT ENTITIES.—In entering into contracts under paragraph (1), the Director shall ensure that at least one contract is entered into with a non-profit entity.

''(4) ADMINISTRATION.—The Director shall implement this subsection in a manner similar to the manner in which the Director implements the contracting provisions with respect to carriers under the Federal employees health benefit program under chapter 89 of title 5, United States Code, including (through negotiating with each multi-state plan)—

''(A) a medical loss ratio;

''(B) a profit margin;

''(C) the premiums to be charged; and

''(D) such other terms and conditions of coverage as are in the interests of enrollees in such plans.

''(5) AUTHORITY TO PROTECT CONSUMERS.—The Director may prohibit the offering of any multi-State health plan that does not

meet the terms and conditions defined by the Director with respect to the elements described in subparagraphs (A) through (D) of paragraph (4).

''(6) ASSURED AVAILABILITY OF VARIED COVERAGE.—In entering into contracts under this subsection, the Director shall ensure that with respect to multi-State qualified health plans offered in an Exchange, there is at least one such plan that does not provide coverage of services described in section 1303(b)(1)(B)(i).

''(7) WITHDRAWAL.—Approval of a contract under this subsection may be withdrawn by the Director only after notice and opportunity for hearing to the issuer concerned without regard to subchapter II of chapter 5 and chapter 7 of title 5, United States Code.

''(b) ELIGIBILITY.—A health insurance issuer shall be eligible to enter into a contract under subsection (a)(1) if such issuer—

''(1) agrees to offer a multi-State qualified health plan that meets the requirements of subsection (c) in each Exchange in each State;

''(2) is licensed in each State and is subject to all requirements of State law not inconsistent with this section, including 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 Public Health Service Act or a requirement of this title;

''(3) otherwise complies with the minimum standards prescribed for carriers offering health benefits plans under section 8902(e) of title 5, United States Code, to the extent that such standards do not conflict with a provision of this title; and

''(4) meets such other requirements as determined appropriate by the Director, in consultation with the Secretary.

''(c) REQUIREMENTS FOR MULTI-STATE QUALIFIED HEALTH PLAN.—

''(1) IN GENERAL.—A multi-State qualified health plan meets the requirements of this subsection if, in the determination of the Director—

''(A) the plan offers a benefits package that is uniform in each State and consists of the essential benefits described in section 1302;

''(B) the plan meets all requirements of this title with respect to a qualified health plan, including requirements relating to the offering of the bronze, silver, and gold levels of coverage and catastrophic coverage in each State Exchange;

''(C) except as provided in paragraph (5), the issuer provides for determinations of premiums for coverage under the plan on the basis of the rating requirements of part A of title XXVII of the Public Health Service Act; and

''(D) the issuer offers the plan in all geographic regions, and in all States that have adopted adjusted community rating before the date of enactment of this Act.

''(2) STATES MAY OFFER ADDITIONAL BENEFITS.—Nothing in paragraph (1)(A) shall preclude a State from requiring that benefits in addition to the essential health benefits required under such paragraph be provided to enrollees of a multi-State qualified health plan offered in such State.

''(3) CREDITS.—

''(A) IN GENERAL.—An individual enrolled in a multi-State qualified health plan under this section shall be eligible for credits under section 36B of the Internal Revenue Code of 1986 and cost sharing assistance under section 1402 in the same manner as an individual who is enrolled in a qualified health plan.

''(B) NO ADDITIONAL FEDERAL COST.—A requirement by a State under paragraph (2) that benefits in addition to the essential health benefits required under paragraph (1)(A) be provided to enrollees of a multi-State qualified health plan shall not affect the amount of a premium tax credit provided under section 36B of the Internal Revenue Code of 1986 with respect to such plan.

''(4) STATE MUST ASSUME COST.—A State shall make payments—

''(A) to an individual enrolled in a multi-State qualified health plan offered in such State; or

''(B) on behalf of an individual described in subparagraph (A) directly to the multi-State qualified health plan in which such individual is enrolled;

to defray the cost of any additional benefits described in paragraph (2).

''(5) APPLICATION OF CERTAIN STATE RATING REQUIREMENTS.—With respect to a multi-State qualified health plan that is offered in a State with age rating requirements that are lower than 3:1, the State may require that Exchanges operating in such State only permit the offering of such multi-State qualified health plans if such plans comply with the State's more protective age rating requirements.

''(d) PLANS DEEMED TO BE CERTIFIED.—A multi-State qualified health plan that is offered under a contract under subsection (a) shall be deemed to be certified by an Exchange for purposes of section 1311(d)(4)(A).

''(e) PHASE-IN.—Notwithstanding paragraphs (1) and (2) of subsection (b), the Director shall enter into a contract with a health insurance issuer for the offering of a multi-State qualified health plan under subsection (a) if—

''(1) with respect to the first year for which the issuer offers such plan, such issuer offers the plan in at least 60 percent of the States;

''(2) with respect to the second such year, such issuer offers the plan in at least 70 percent of the States;

''(3) with respect to the third such year, such issuer offers the plan in at least 85 percent of the States; and

''(4) with respect to each subsequent year, such issuer offers the plan in all States.

''(f) APPLICABILITY.—The requirements under chapter 89 of title 5, United States Code, applicable to health benefits plans under such chapter shall apply to multi-State qualified health plans provided for under this section to the extent that such requirements do not conflict with a provision of this title.

''(g) CONTINUED SUPPORT FOR FEHBP.—

''(1) MAINTENANCE OF EFFORT.—Nothing in this section shall be construed to permit the Director to allocate fewer financial or personnel resources to the functions of the Office of Personnel Management related to the administration of the Federal Employees Health Benefit Program under chapter 89 of title 5, United States Code.

''(2) SEPARATE RISK POOL.—Enrollees in multi-State qualified health plans under this section shall be treated as a separate risk pool apart from enrollees in the Federal Employees Health Benefit Program under chapter 89 of title 5, United States Code.

''(3) AUTHORITY TO ESTABLISH SEPARATE ENTITIES.—The Director may establish such separate units or offices within the Office of Personnel Management as the Director determines to be appropriate to ensure that the administration of multi-State qualified health plans under this section does not interfere with the effective administration of the Federal Employees Health Benefit Program under chapter 89 of title 5, United States Code.

''(4) EFFECTIVE OVERSIGHT.—The Director may appoint such additional personnel as may be necessary to enable the Director to carry out activities under this section.

''(5) ASSURANCE OF SEPARATE PROGRAM.—In carrying out this section, the Director shall ensure that the program under this section is separate from the Federal Employees Health Benefit Program under chapter 89 of title 5, United States Code. Premiums paid for coverage under a multi-State qualified health plan under this section shall not be considered to be Federal funds for any purposes.

''(6) FEHBP PLANS NOT REQUIRED TO PARTICIPATE.—Nothing in this section shall require that a carrier offering coverage under the Federal Employees Health Benefit Program under chapter 89 of title 5, United States Code, also offer a multi-State qualified health plan under this section.

''(h) ADVISORY BOARD.—The Director shall establish an advisory board to provide recommendations on the activities described in this section. A significant percentage of the members of such board shall be comprised of enrollees in a multi-State qualified health plan, or representatives of such enrollees.

''(i) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated, such sums as may be necessary to carry out this section.''.

(r) Section 1341 of this Act is amended—

(1) in the section heading, by striking ''AND SMALL GROUP MARKETS'' and inserting ''MARKET'';

(2) in subsection (b)(2)(B), by striking ''paragraph (1)(A)'' and inserting ''paragraph (1)(B)''; and

(3) in subsection (c)(1)(A), by striking ''and small group markets'' and inserting ''market''.

SEC. 10105. AMENDMENTS TO SUBTITLE E.

(a) Section 36B(b)(3)(A)(ii) of the Internal Revenue Code of 1986, as added by section 1401(a) of this Act, is amended by striking ''is in excess of'' and inserting ''equals or exceeds''.

(b) Section 36B(c)(1)(A) of the Internal Revenue Code of 1986, as added by section 1401(a) of this Act, is amended by inserting ''equals or'' before ''exceeds''.

(c) Section 36B(c)(2)(C)(iv) of the Internal Revenue Code of 1986, as added by section 1401(a) of this Act, is amended by striking ''subsection (b)(3)(A)(ii)'' and inserting ''subsection (b)(3)(A)(iii)''.

(d) Section 1401(d) of this Act is amended by adding at the end the following:

''(3) Section 6211(b)(4)(A) of the Internal Revenue Code of 1986 is amended by inserting '36B,' after '36A,'.''.

(e)(1) Subparagraph (B) of section 45R(d)(3) of the Internal Revenue Code of 1986, as added by section 1421(a) of this Act, is amended to read as follows:

''(B) DOLLAR AMOUNT.—For purposes of paragraph (1)(B) and subsection (c)(2)—

''(i) 2010, 2011, 2012, AND 2013.—The dollar amount in effect under this paragraph for taxable years beginning in 2010, 2011, 2012, or 2013 is $25,000.

''(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 $25,000, multiplied by the cost-of-living adjustment under section 1(f)(3) for the calendar year, determined by substituting 'calendar year 2012' for 'calendar year 1992' in subparagraph (B) thereof.''.

(2) Subsection (g) of section 45R of the Internal Revenue Code of 1986, as added by section 1421(a) of this Act, is amended by striking ''2011'' both places it appears and inserting ''2010, 2011''.

(3) Section 280C(h) of the Internal Revenue Code of 1986, as added by section 1421(d)(1) of this Act, is amended by striking ''2011'' and inserting ''2010, 2011''.

(4) Section 1421(f) of this Act is amended by striking ''2010'' both places it appears and inserting ''2009''.

(5) The amendments made by this subsection shall take effect as if included in the enactment of section 1421 of this Act.

(f) Part I of subtitle E of title I of this Act is amended by adding at the end of subpart B, the following:

"SEC. 1416. STUDY OF GEOGRAPHIC VARIATION IN APPLICATION OF FPL.

''(a) IN GENERAL.—The Secretary shall conduct a study to examine the feasibility and implication of adjusting the application of the Federal poverty level under this subtitle (and the amendments made by this subtitle) for different geographic areas so as to reflect the variations in cost-of-living among different areas within the United States. If the Secretary determines that an adjustment is feasible, the study should include a methodology to make such an adjustment. Not later than January 1, 2013, the Secretary shall submit to Congress a report on such study and shall include such recommendations as the Secretary determines appropriate.

''(b) INCLUSION OF TERRITORIES.—

''(1) IN GENERAL.—The Secretary shall ensure that the study under subsection (a) covers the territories of the United States and that special attention is paid to the disparity that exists among poverty levels and the cost of living in such territories and to the impact of such disparity on efforts to expand health coverage and ensure health care.

''(2) TERRITORIES DEFINED.—In this subsection, the term 'territories of the United States' includes the Commonwealth of Puerto Rico, the United States Virgin Islands, Guam, the Northern Mariana Islands, and any other territory or possession of the United States.''.

SEC. 10106. AMENDMENTS TO SUBTITLE F.

(a) Section 1501(a)(2) of this Act is amended to read as follows:

''(2) EFFECTS ON THE NATIONAL ECONOMY AND INTERSTATE COMMERCE.—The effects described in this paragraph are the following:

''(A) The requirement regulates activity that is commercial and economic in nature: economic and financial decisions about how and when health care is paid for, and when health insurance is purchased. In the absence of the requirement, some individuals would make an economic and financial decision to forego health insurance coverage and attempt to self-insure, which increases financial risks to households and medical providers.

''(B) Health insurance and health care services are a significant part of the national economy. National health spending is projected to increase from $2,500,000,000,000, or 17.6 percent of the economy, in 2009 to $4,700,000,000,000 in 2019. Private health insurance spending is projected to be $854,000,000,000 in 2009, and pays for medical supplies, drugs, and equipment that are shipped in interstate commerce. Since most health insurance is sold by national or regional health insurance companies, health insurance is sold in interstate commerce and claims payments 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, and 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) The economy loses up to $207,000,000,000 a year because of the poorer health and shorter lifespan of the uninsured. By significantly reducing the number of the uninsured, the requirement, together with the other provisions of this Act, will significantly reduce this economic cost.

''(F) The cost of providing uncompensated care to the uninsured was $43,000,000,000 in 2008. To pay for this cost, health care providers pass on the cost to private insurers, which pass on the cost to families. This cost-shifting increases family premiums by on average over $1,000 a year. By significantly reducing the number of the uninsured, the requirement, together with the other provisions of this Act, will lower health insurance premiums.

''(G) 62 percent 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.

''(H) Under the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.), the Public Health Service Act (42 U.S.C. 201 et seq.), and this Act, the Federal Government has a significant role in regulating health insurance. The requirement is an essential part of this larger regulation of economic activity, and the absence of the requirement would undercut Federal regulation of the health insurance market.

''(I) Under sections 2704 and 2705 of the Public Health Service Act (as added by section 1201 of this Act), if there were no requirement, many individuals would wait to purchase health insurance until they needed care. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums. The requirement is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold.

''(J) Administrative costs for private health insurance, which were $90,000,000,000 in 2006, are 26 to 30 percent of premiums in the current individual and small group markets. By significantly increasing health insurance coverage 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.''.

(b)(1) Section 5000A(b)(1) of the Internal Revenue Code of 1986, as added by section 1501(b) of this Act, is amended to read as follows:

''(1) IN GENERAL.—If a taxpayer who is an applicable individual, or an applicable individual for whom the taxpayer is liable under paragraph (3), fails to meet the requirement of subsection (a) for 1 or more months, then, except as provided in subsection (e), there is hereby imposed on the taxpayer a penalty with respect to such failures in the amount determined under subsection (c).''.

(2) Paragraphs (1) and (2) of section 5000A(c) of the Internal Revenue Code of 1986, as so added, are amended to read as follows:

''(1) IN GENERAL.—The amount of the penalty imposed by this section on any taxpayer for any taxable year with respect to failures described in subsection (b)(1) shall be equal to the lesser of—

''(A) the sum of the monthly penalty amounts determined under paragraph (2) for months in the taxable year during which 1 or more such failures occurred, or

''(B) an amount equal to the national average premium for qualified health plans which have a bronze level of coverage, provide coverage for the applicable family size involved, and are offered through Exchanges for plan years beginning in the calendar year with or within which the taxable year ends.

''(2) MONTHLY PENALTY AMOUNTS.—For purposes of paragraph (1)(A), the monthly penalty amount with respect to any taxpayer for any month during which any failure described in subsection (b)(1) occurred is an amount equal to 1/12 of the greater of the following amounts:

''(A) FLAT DOLLAR AMOUNT.—An amount equal to the lesser of—

''(i) the sum of the applicable dollar amounts for all individuals with respect to whom such failure occurred during such month, or

''(ii) 300 percent of the applicable dollar amount (determined without regard to paragraph (3)(C)) for the calendar year with or within which the taxable year ends.

''(B) PERCENTAGE OF INCOME.—An amount equal to the following percentage of the taxpayer's household income for the taxable year:

''(i) 0.5 percent for taxable years beginning in 2014.

''(ii) 1.0 percent for taxable years beginning in 2015.

''(iii) 2.0 percent for taxable years beginning after 2015.''.

(3) Section 5000A(c)(3) of the Internal Revenue Code of 1986, as added by section 1501(b) of this Act, is amended by striking ''$350'' and inserting ''$495''.

(c) Section 5000A(d)(2)(A) of the Internal Revenue Code of 1986, as added by section 1501(b) of this Act, is amended to read as follows:

''(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—

''(i) a member of a recognized religious sect or division thereof which is described in section 1402(g)(1), and

''(ii) an adherent of established tenets or teachings of such sect or division as described in such section.''.

(d) Section 5000A(e)(1)(C) of the Internal Revenue Code of 1986, as added by section 1501(b) of this Act, is amended to read as follows:

''(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 under subparagraph (A) shall be made by reference to required contribution of the employee.''.

(e) Section 4980H(b) of the Internal Revenue Code of 1986, as added by section 1513(a) of this Act, is amended to read as follows:

''(b) LARGE EMPLOYERS WITH WAITING PERIODS EXCEEDING 60 DAYS.—

''(1) IN GENERAL.—In the case of any applicable large employer which requires an extended waiting period to enroll in any minimum essential coverage under an employer-sponsored plan (as defined in section 5000A(f)(2)), there is hereby imposed on the employer an assessable payment of $600 for each full-time employee of the employer to whom the extended waiting period applies.

''(2) EXTENDED WAITING PERIOD.—The term 'extended waiting period' means any waiting period (as defined in section 2701(b)(4) of the Public Health Service Act) which exceeds 60 days.''.

(f)(1) Subparagraph (A) of section 4980H(d)(4) of the Internal Revenue Code of 1986, as added by section 1513(a) of this Act, is amended by inserting '', with respect to any month,'' after ''means''.

(2) Section 4980H(d)(2) of the Internal Revenue Code of 1986, as added by section 1513(a) of this Act, is amended by adding at the end the following:

''(D) APPLICATION TO CONSTRUCTION INDUSTRY EMPLOYERS.—In the case of any employer the substantial annual gross receipts of which are attributable to the construction industry—

''(i) subparagraph (A) shall be applied by substituting 'who employed an average of at least 5 full-time employees on business days during the preceding calendar year and whose annual payroll expenses exceed $250,000 for such preceding calendar year' for 'who employed an average of at least 50 full-time employees on business days during the preceding calendar year', and

''(ii) subparagraph (B) shall be applied by substituting '5' for '50'.''.

(3) The amendment made by paragraph (2) shall apply to months beginning after December 31, 2013.

(g) Section 6056(b) of the Internal Revenue Code of 1986, as added by section 1514(a) of the Act, is amended by adding at the end the following new flush sentence:

''The Secretary shall have the authority to review the accuracy of the information provided under this subsection, including the applicable large employer's share under paragraph (2)(C)(iv).''.

SEC. 10107. AMENDMENTS TO SUBTITLE G.

(a) Section 1562 of this Act is amended, in the amendment made by subsection (a)(2)(B)(iii), by striking ''subpart 1'' and inserting ''subparts I and II''; and

(b) Subtitle G of title I of this Act is amended—

(1) by redesignating section 1562 (as amended) as section 1563; and

(2) by inserting after section 1561 the following:

''SEC. 1562. GAO STUDY REGARDING THE RATE OF DENIAL OF COVERAGE AND ENROLLMENT BY HEALTH INSURANCE ISSUERS AND GROUP HEALTH PLANS.

''(a) IN GENERAL.—The Comptroller General of the United States (referred to in this section as the 'Comptroller General') shall conduct a study of the incidence of denials of coverage for medical services and denials of applications to enroll in health insurance plans, as described in subsection (b), by group health plans and health insurance issuers.

''(b) DATA.—

''(1) IN GENERAL.—In conducting the study described in subsection (a), the Comptroller General shall consider samples of data concerning the following:

''(A)(i) denials of coverage for medical services to a plan enrollees, by the types of services for which such coverage was denied; and

''(ii) the reasons such coverage was denied; and

''(B)(i) incidents in which group health plans and health insurance issuers deny the application of an individual to enroll in a health insurance plan offered by such group health plan or issuer; and

''(ii) the reasons such applications are denied.

''(2) SCOPE OF DATA.—

''(A) FAVORABLY RESOLVED DISPUTES.—The data that the Comptroller General considers under paragraph (1) shall include data concerning denials of coverage for medical services and denials of applications for enrollment in a plan by a group health plan or health insurance issuer, where such group health plan or health insurance issuer later approves such coverage or application.

''(B) ALL HEALTH PLANS.—The study under this section shall consider data from varied group health plans and health insurance plans offered by health insurance issuers, including qualified health plans and health plans that are not qualified health plans.

''(c) REPORT.—Not later than one year after the date of enactment of this Act, the Comptroller General shall submit to the Secretaries of Health and Human Services and Labor a report describing the results of the study conducted under this section.

''(d) PUBLICATION OF REPORT.—The Secretaries of Health and Human Services and Labor shall make the report described in subsection (c) available to the public on an Internet website.

''SEC. 1563. SMALL BUSINESS PROCUREMENT.

''Part 19 of the Federal Acquisition Regulation, section 15 of the Small Business Act (15 U.S.C. 644), and any other applicable laws or regulations establishing procurement requirements relating to small business concerns (as defined in section 3 of the Small Business Act (15 U.S.C. 632)) may not be waived with respect to any contract awarded under any program or other authority under this Act or an amendment made by this Act.''.

SEC. 10108. FREE CHOICE VOUCHERS.

(a) IN GENERAL.—An offering employer shall provide free choice vouchers to each qualified employee of such employer.

(b) OFFERING EMPLOYER.—For purposes of this section, the term ''offering employer'' means any employer who—

(1) offers minimum essential coverage to its employees consisting of coverage through an eligible employer-sponsored plan; and

(2) pays any portion of the costs of such plan.

(c) QUALIFIED EMPLOYEE.—For purposes of this section—

(1) IN GENERAL.—The term ''qualified employee'' means, with respect to any plan year of an offering employer, any employee—

(A) whose required contribution (as determined under section 5000A(e)(1)(B)) for minimum essential coverage through an eligible employer-sponsored plan—

(i) exceeds 8 percent of such employee's household income for the taxable year described in section 1412(b)(1)(B) which ends with or within in the plan year; and

(ii) does not exceed 9.8 percent of such employee's household income for such taxable year;

(B) whose household income for such taxable year is not greater than 400 percent of the poverty line for a family of the size involved; and

(C) who does not participate in a health plan offered by the offering employer.

(2) INDEXING.—In the case of any calendar year beginning after 2014, the Secretary shall adjust the 8 percent under paragraph (1)(A)(i) and 9.8 percent under paragraph (1)(A)(ii) for the calendar year to reflect the rate of premium growth between the preceding calendar year and 2013 over the rate of income growth for such period.

(d) FREE CHOICE VOUCHER.—

(1) AMOUNT.—

(A) IN GENERAL.—The amount of any free choice voucher provided under subsection (a) shall be equal to the monthly portion of the cost of the eligible employer-sponsored plan which would have been paid by the employer if the employee were covered under the plan with respect to which the employer pays the largest portion of the cost of the plan. Such amount shall be equal to the amount the employer would pay for an employee with self-only coverage unless such employee elects family coverage (in which case such amount shall be the amount the employer would pay for family coverage).

(B) DETERMINATION OF COST.—The cost of any health plan shall be determined under the rules similar to the rules of section 2204 of the Public Health Service Act, except that such amount shall be adjusted for age and category of enrollment in accordance with regulations established by the Secretary.

(2) USE OF VOUCHERS.—An Exchange shall credit the amount of any free choice voucher provided under subsection (a) to the monthly premium of any qualified health plan in the Exchange in which the qualified employee is enrolled and the offering employer shall pay any amounts so credited to the Exchange.

(3) PAYMENT OF EXCESS AMOUNTS.—If the amount of the free choice voucher exceeds the amount of the premium of the qualified health plan in which the qualified employee is enrolled for such month, such excess shall be paid to the employee.

(e) OTHER DEFINITIONS.—Any term used in this section which is also used in section 5000A of the Internal Revenue Code of 1986 shall have the meaning given such term under such section 5000A.

(f) EXCLUSION FROM INCOME FOR EMPLOYEE.—

(1) 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. FREE CHOICE VOUCHERS.

''Gross income shall not include the amount of any free choice voucher provided by an employer under section 10108 of the Patient Protection and Affordable Care Act to the extent that the amount of such voucher does not exceed the amount paid for a qualified health plan (as defined in section 1301 of such Act) by the taxpayer.''.

(2) CLERICAL AMENDMENT.—The table of sections for part III of subchapter B of chapter 1 of such Code is amended by inserting after the item relating to section 139C the following new item:

''Sec. 139D. Free choice vouchers.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to vouchers provided after December 31, 2013.

(g) DEDUCTION ALLOWED TO EMPLOYER.—

(1) IN GENERAL.—Section 162(a) of the Internal Revenue Code of 1986 is amended by adding at the end the following new sentence: ''For purposes of paragraph (1), the amount of a free choice voucher provided under section 10108 of the Patient Protection and Affordable Care Act shall be treated as an amount for compensation for personal services actually rendered.''.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to vouchers provided after December 31, 2013.

(h) VOUCHER TAKEN INTO ACCOUNT IN DETERMINING PREMIUM CREDIT.—

(1) IN GENERAL.—Subsection (c)(2) of section 36B of the Internal Revenue Code of 1986, as added by section 1401, is amended by adding at the end the following new subparagraph:

''(D) EXCEPTION FOR INDIVIDUAL RECEIVING FREE CHOICE VOUCHERS.—The term 'coverage month' shall not include any month in which such individual has a free choice voucher provided under section 10108 of the Patient Protection and Affordable Care Act.''.

(2) EFFECTIVE DATE.—The amendment made by this subsection shall apply to taxable years beginning after December 31, 2013.

(i) COORDINATION WITH EMPLOYER RESPONSIBILITIES.—

(1) SHARED RESPONSIBILITY PENALTY.—

(A) IN GENERAL.—Subsection (c) of section 4980H of the Internal Revenue Code of 1986, as added by section 1513, is amended by adding at the end the following new paragraph:

''(3) SPECIAL RULES FOR EMPLOYERS PROVIDING FREE CHOICE VOUCHERS.—No assessable payment shall be imposed under paragraph (1) for any month with respect to any employee to whom the employer provides a free choice voucher under section 10108 of the Patient Protection and Affordable Care Act for such month.''.

(B) EFFECTIVE DATE.—The amendment made by this paragraph shall apply to months beginning after December 31, 2013.

(2) NOTIFICATION REQUIREMENT.—Section 18B(a)(3) of the Fair Labor Standards Act of 1938, as added by section 1512, is amended—

(A) by inserting ''and the employer does not offer a free choice voucher'' after ''Exchange''; and

(B) by striking ''will lose'' and inserting ''may lose''.

(j) EMPLOYER REPORTING.—

(1) IN GENERAL.—Subsection (a) of section 6056 of the Internal Revenue Code of 1986, as added by section 1514, is amended by inserting ''and every offering employer'' before ''shall''.

(2) OFFERING EMPLOYERS.—Subsection (f) of section 6056 of such Code, as added by section 1514, is amended to read as follows:

''(f) DEFINITIONS.—For purposes of this section—

''(1) OFFERING EMPLOYER.—

''(A) IN GENERAL.—The term 'offering employer' means any offering employer (as defined in section 10108(b) of the Patient Protection and Affordable Care Act) if the required contribution (within the meaning of section 5000A(e)(1)(B)(i)) of any employee exceeds 8 percent of the wages (as defined in section 3121(a)) paid to such employee by such employer.

''(B) INDEXING.—In the case of any calendar year beginning after 2014, the 8 percent under subparagraph (A) shall be adjusted for the calendar year to reflect the rate of premium growth between the preceding calendar year and 2013 over the rate of income growth for such period.

''(2) OTHER DEFINITIONS.—Any term used in this section which is also used in section 4980H shall have the meaning given such term by section 4980H.''.

(3) CONFORMING AMENDMENTS.—

(A) The heading of section 6056 of such Code, as added by section 1514, is amended by striking ''LARGE'' and inserting ''CERTAIN''.

(B) Section 6056(b)(2)(C) of such Code is amended—

(i) by inserting ''in the case of an applicable large employer,'' before ''the length'' in clause (i);

(ii) by striking ''and'' at the end of clause (iii);

(iii) by striking ''applicable large employer'' in clause (iv) and inserting ''employer'';

(iv) by inserting ''and'' at the end of clause (iv); and

(v) by inserting at the end the following new clause:

''(v) in the case of an offering employer, the option for which the employer pays the largest portion of the cost of the plan and the portion of the cost paid by the employer in each of the enrollment categories under such option,''.

(C) Section 6056(d)(2) of such Code is amended by inserting ''or offering employer'' after ''applicable large employer''.

(D) Section 6056(e) of such Code is amended by inserting ''or offering employer'' after ''applicable large employer''.

(E) Section 6724(d)(1)(B)(xxv) of such Code, as added by section 1514, is amended by striking ''large'' and inserting ''certain''.

(F) Section 6724(d)(2)(HH) of such Code, as added by section 1514, is amended by striking ''large'' and inserting ''certain''.

(G) The table of sections for subpart D of part III of subchapter A of chapter 1 of such Code, as amended by section 1514, is amended by striking ''Large employers'' in the item relating to section 6056 and inserting ''Certain employers''.

(4) EFFECTIVE DATE.—The amendments made by this subsection shall apply to periods beginning after December 31, 2013.

SEC. 10109. DEVELOPMENT OF STANDARDS FOR FINANCIAL AND ADMINISTRATIVE TRANSACTIONS.

(a) ADDITIONAL TRANSACTION STANDARDS AND OPERATING RULES.—

(1) DEVELOPMENT OF ADDITIONAL TRANSACTION STANDARDS AND OPERATING RULES.—Section 1173(a) of the Social Security Act (42 U.S.C. 1320d–2(a)), as amended by section 1104(b)(2), is amended—

(A) in paragraph (1)(B), by inserting before the period the following: '', and subject to the requirements under paragraph (5)''; and

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

''(5) CONSIDERATION OF STANDARDIZATION OF ACTIVITIES AND ITEMS.—

''(A) IN GENERAL.—For purposes of carrying out paragraph (1)(B), the Secretary shall solicit, not later than January 1, 2012, and not less than every 3 years thereafter, input from entities described in subparagraph (B) on—

''(i) whether there could be greater uniformity in financial and administrative activities and items, as determined appropriate by the Secretary; and

''(ii) whether such activities should be considered financial and administrative transactions (as described in paragraph (1)(B)) for which the adoption of standards and operating rules would improve the operation of the health care system and reduce administrative costs.

''(B) SOLICITATION OF INPUT.—For purposes of subparagraph (A), the Secretary shall seek input from—

''(i) the National Committee on Vital and Health Statistics, the Health Information Technology Policy Committee, and the Health Information Technology Standards Committee; and

''(ii) standard setting organizations and stakeholders, as determined appropriate by the Secretary.''.

(b) ACTIVITIES AND ITEMS FOR INITIAL CONSIDERATION.—For purposes of section 1173(a)(5) of the Social Security Act, as added by subsection (a), the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall, not later than January 1, 2012, seek input on activities and items relating to the following areas:

(1) Whether the application process, including the use of a uniform application form, for enrollment of health care providers by health plans could be made electronic and standardized.

(2) Whether standards and operating rules described in section 1173 of the Social Security Act should apply to the health care transactions of automobile insurance, worker's compensation, and other programs or persons not described in section 1172(a) of such Act (42 U.S.C. 1320d–1(a)).

(3) Whether standardized forms could apply to financial audits required by health plans, Federal and State agencies (including State auditors, the Office of the Inspector General of the Department of Health and Human Services, and the Centers for Medicare & Medicaid Services), and other relevant entities as determined appropriate by the Secretary.

(4) Whether there could be greater transparency and consistency of methodologies and processes used to establish claim edits used by health plans (as described in section 1171(5) of the Social Security Act (42 U.S.C. 1320d(5))).

(5) Whether health plans should be required to publish their timeliness of payment rules.

(c) ICD CODING CROSSWALKS.—

(1) ICD-9 TO ICD-10 CROSSWALK.—The Secretary shall task the ICD-9-CM Coordination and Maintenance Committee to convene a meeting, not later than January 1, 2011, to receive input from appropriate stakeholders (including health plans, health care providers, and clinicians) regarding the crosswalk between the Ninth and Tenth Revisions of the International Classification of Diseases (ICD-9 and ICD-10, respectively) that is posted on the website of the Centers for Medicare & Medicaid Services, and make recommendations about appropriate revisions to such crosswalk.

(2) REVISION OF CROSSWALK.—For purposes of the crosswalk described in paragraph (1), the Secretary shall make appropriate revisions and post any such revised crosswalk on the website of the Centers for Medicare & Medicaid Services.

(3) USE OF REVISED CROSSWALK.—For purposes of paragraph (2), any revised crosswalk shall be treated as a code set for which a standard has been adopted by the Secretary for purposes of section 1173(c)(1)(B) of the Social Security Act (42 U.S.C. 1320d–2(c)(1)(B)).

(4) SUBSEQUENT CROSSWALKS.—For subsequent revisions of the International Classification of Diseases that are adopted by the Secretary as a standard code set under section 1173(c) of the Social Security Act (42 U.S.C. 1320d–2(c)), the Secretary shall, after consultation with the appropriate stakeholders, post on the website of the Centers for Medicare & Medicaid Services a crosswalk between the previous and subsequent version of the International Classification of Diseases not later than the date of implementation of such subsequent revision.

Subtitle B—Provisions Relating to Title II

PART I—MEDICAID AND CHIP

SEC. 10201. AMENDMENTS TO THE SOCIAL SECURITY ACT AND TITLE II OF THIS ACT.

(a)(1) Section 1902(a)(10)(A)(i)(IX) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)(IX)), as added by section 2004(a), is amended to read as follows:

''(IX) who—

''(aa) are under 26 years of age;

''(bb) are not described in or enrolled under any of subclauses (I) through (VII) of this clause or are described in any of such subclauses but have income that exceeds the level of income applicable under the State plan for eligibility to enroll for medical assistance under such subclause;

''(cc) were in foster care under the responsibility of the State on the date of attaining 18 years of age or such higher age as the State has elected under section 475(8)(B)(iii); and

''(dd) were enrolled in the State plan under this title or under a waiver of the plan while in such foster care;''.

(2) 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), by striking ''and (XV)'' and inserting ''(XV)'', and by inserting ''and (XVI) if an individual is described in subclause (IX) of subparagraph (A)(i) and is also described in subclause (VIII) of that subparagraph, the medical assistance shall be made available to the individual through subclause (IX) instead of through subclause (VIII)'' before the semicolon.

(3) Section 2004(d) of this Act is amended by striking ''2019'' and inserting ''2014''.

(b) Section 1902(k)(2) of the Social Security Act (42 U.S.C. 1396a(k)(2)), as added by section 2001(a)(4)(A), is amended by striking

''January 1, 2011'' and inserting ''April 1, 2010''.

(c) Section 1905 of the Social Security Act (42 U.S.C. 1396d), as amended by sections 2001(a)(3), 2001(a)(5)(C), 2006, and 4107(a)(2), is amended—

(1) in subsection (a), in the matter preceding paragraph (1), by inserting in clause (xiv), ''or 1902(a)(10)(A)(i)(IX)'' before the comma;

(2) in subsection (b), in the first sentence, by inserting '', (z),'' before ''and (aa)'';

(3) in subsection (y)—

(A) in paragraph (1)(B)(ii)(II), in the first sentence, by inserting ''includes inpatient hospital services,'' after ''100 percent of the poverty line, that''; and

(B) in paragraph (2)(A), by striking ''on the date of enactment of the Patient Protection and Affordable Care Act'' and inserting ''as of December 1, 2009'';

(4) by inserting after subsection (y) the following:

''(z) EQUITABLE SUPPORT FOR CERTAIN STATES.—

''(1)(A) During the period that begins on January 1, 2014, and ends on September 30, 2019, notwithstanding subsection (b), the Federal medical assistance percentage otherwise determined under subsection (b) with respect to a fiscal year occurring during that period shall be increased by 2.2 percentage points for any State described in subparagraph (B) for amounts expended for medical assistance for individuals who are not newly eligible (as defined in subsection (y)(2)) individuals described in subclause (VIII) of section 1902(a)(10)(A)(i).

''(B) For purposes of subparagraph (A), a State described in this subparagraph is a State that—

''(i) is an expansion State described in subsection (y)(1)(B)(ii)(II);

''(ii) the Secretary determines will not receive any payments under this title on the basis of an increased Federal medical assistance percentage under subsection (y) for expenditures for medical assistance for newly eligible individuals (as so defined); and

''(iii) has not been approved by the Secretary to divert a portion of the DSH allotment for a State to the costs of providing medical assistance or other health benefits coverage under a waiver that is in effect on July 2009.

''(2)(A) During the period that begins on January 1, 2014, and ends on December 31, 2016, notwithstanding subsection (b), the Federal medical assistance percentage otherwise determined under subsection (b) with respect to all or any portion of a fiscal year occurring during that period shall be increased by .5 percentage point for a State described in subparagraph (B) for amounts expended for medical assistance under the State plan under this title or under a waiver of that plan during that period.

''(B) For purposes of subparagraph (A), a State described in this subparagraph is a State that—

''(i) is described in clauses (i) and (ii) of paragraph (1)(B); and

''(ii) is the State with the highest percentage of its population insured during 2008, based on the Current Population Survey.

''(3) Notwithstanding subsection (b) and paragraphs (1) and (2) of this subsection, the Federal medical assistance percentage otherwise determined under subsection (b) with respect to all or any portion of a fiscal year that begins on or after January 1, 2017, for the State of Nebraska, with respect to amounts expended for newly eligible individuals described in subclause (VIII) of section 1902(a)(10)(A)(i), shall be determined as provided for under subsection (y)(1)(A) (notwithstanding the period provided for in such paragraph).

''(4) The increase in the Federal medical assistance percentage for a State under paragraphs (1), (2), or (3) shall apply only for purposes of this title and shall not apply with respect to—

''(A) disproportionate share hospital payments described in section 1923;

''(B) payments under title IV;

''(C) payments under title XXI; and

''(D) payments under this title that are based on the enhanced FMAP described in section 2105(b).'';

(5) in subsection (aa), is amended by striking ''without regard to this subsection and subsection (y)'' and inserting ''without regard to this subsection, subsection (y), subsection (z), and section 10202 of the Patient Protection and Affordable Care Act'' each place it appears;

(6) by adding after subsection (bb), the following:

''(cc) REQUIREMENT FOR CERTAIN STATES.—Notwithstanding subsections (y), (z), and (aa), in the case of a State that requires political subdivisions within the State to contribute toward the non-Federal share of expenditures required under the State plan under section 1902(a)(2), the State shall not be eligible for an increase in its Federal medical assistance percentage under such subsections if it requires that political subdivisions pay a greater percentage of the non-Federal share of such expenditures, or a greater percentage of the non-Federal share of payments under section 1923, than the respective percentages that would have been required by the State under the State plan under this title, State law, or both, as in effect on December 31, 2009, and without regard to any such increase. Voluntary contributions by a political subdivision to the non-Federal share of expenditures under the State plan under this title or to the non-Federal share of payments under section 1923, shall not be considered to be required contributions for purposes of this subsection. The treatment of voluntary contributions, and the treatment of contributions required by a State under the State plan under this title, or State law, as provided by this subsection, shall also apply to the increases in the Federal medical assistance percentage under section 5001 of the American Recovery and Reinvestment Act of 2009.''.

(d) Section 1108(g)(4)(B) of the Social Security Act (42 U.S.C. 1308(g)(4)(B)), as added by section 2005(b), is amended by striking ''income eligibility level in effect for that population under title XIX or under a waiver'' and inserting ''the highest income eligibility level in effect for parents under the commonwealth's or territory's State plan under title XIX or under a waiver of the plan''.

(e)(1) Section 1923(f) of the Social Security Act (42 U.S.C. 1396r–4(f)), as amended by section 2551, is amended—

(A) in paragraph (6)—

(i) by striking the paragraph heading and inserting the following: ''ALLOTMENT ADJUSTMENTS''; and

(ii) in subparagraph (B), by adding at the end the following:

''(iii) ALLOTMENT FOR 2D, 3RD, AND 4TH QUARTER OF FISCAL YEAR 2012, FISCAL YEAR 2013, AND SUCCEEDING FISCAL YEARS.—Notwithstanding the table set forth in paragraph (2) or paragraph (7):

''(I) 2D, 3RD, AND 4TH QUARTER OF FISCAL YEAR 2012.—The DSH allotment for Hawaii for the 2d, 3rd, and 4th quarters of fiscal year 2012 shall be $7,500,000.

''(II) TREATMENT AS A LOW-DSH STATE FOR FISCAL YEAR 2013 AND SUCCEEDING FISCAL YEARS.—With respect to fiscal year 2013, and each fiscal year thereafter, the DSH allotment for Hawaii shall be increased in the same manner as allotments for low DSH States are increased for such fiscal year under clause (iii) of paragraph (5)(B).

''(III) CERTAIN HOSPITAL PAYMENTS.—The Secretary may not impose a limitation on the total amount of payments made to hospitals under the QUEST section 1115 Demonstration Project except to the extent that such limitation is necessary to ensure that a hospital does not receive payments in excess of the amounts described in subsection (g), or as necessary to ensure that such payments under the waiver and such payments pursuant to the allotment provided in this clause do not, in the aggregate in any year, exceed the amount that the Secretary determines is equal to the Federal medical assistance percentage component attributable to disproportionate share hospital payment adjustments for such year that is reflected in the budget neutrality provision of the QUEST Demonstration Project.''; and

(B) in paragraph (7)—

(i) in subparagraph (A), in the matter preceding clause (i), by striking ''subparagraph (E)'' and inserting ''subparagraphs (E) and (G)'';

(ii) in subparagraph (B)—

(I) in clause (i), by striking subclauses (I) and (II), and inserting the following:

''(I) if the State is a low DSH State described in paragraph (5)(B) and has spent not more than 99.90 percent of the DSH allotments for the State on average for the period of fiscal years 2004 through 2008, as of September 30, 2009, the applicable percentage is equal to 25 percent;

''(II) if the State is a low DSH State described in paragraph (5)(B) and has spent more than 99.90 percent of the DSH allotments for the State on average for the period of fiscal years 2004 through 2008, as of September 30, 2009, the applicable percentage is equal to 17.5 percent;

''(III) if the State is not a low DSH State described in paragraph (5)(B) and has spent not more than 99.90 percent of the DSH allotments for the State on average for the period of fiscal years 2004 through 2008, as of September 30, 2009, the applicable percentage is equal to 50 percent; and

''(IV) if the State is not a low DSH State described in paragraph (5)(B) and has spent more than 99.90 percent of the DSH allotments for the State on average for the period of fiscal years 2004 through 2008, as of September 30, 2009, the applicable percentage is equal to 35 percent.'';

(II) in clause (ii), by striking subclauses (I) and (II), and inserting the following:

''(I) if the State is a low DSH State described in paragraph (5)(B) and has spent not more than 99.90 percent of the DSH allotments for the State on average for the period of fiscal years 2004 through 2008, as of September 30, 2009, 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 27.5 percent;

''(II) if the State is a low DSH State described in paragraph (5)(B) and has spent more than 99.90 percent of the DSH allotments for the State on average for the period of fiscal years 2004 through 2008, as of September 30, 2009, 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 20 percent;

''(III) if the State is not a low DSH State described in paragraph (5)(B) and has spent not more than 99.90 percent of the DSH allotments for the State on average for the period of fiscal years 2004 through 2008, as of September 30, 2009, 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 55 percent; and

''(IV) if the State is not a low DSH State described in paragraph (5)(B) and has spent more than 99.90 percent of the DSH allotments for the State on average for the period of fiscal years 2004 through 2008, as of September 30, 2009, 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 40 percent.'';

(III) in subparagraph (E), by striking ''35 percent'' and inserting ''50 percent''; and

(IV) by adding at the end the following:

''(G) NONAPPLICATION.—The preceding provisions of this paragraph shall not apply to the DSH allotment determined for the State of Hawaii for a fiscal year under paragraph (6).''.

(f) Section 2551 of this Act is amended by striking subsection (b).

(g) Section 2105(d)(3)(B) of the Social Security Act (42 U.S.C. 1397ee(d)(3)(B)), as added by section 2101(b)(1), is amended by adding at the end the following: ''For purposes of eligibility for premium assistance for the purchase of a qualified health plan under section 36B of the Internal Revenue Code of 1986 and reduced cost-sharing under section 1402 of the Patient Protection and Affordable Care Act, children described in the preceding sentence shall be deemed to be ineligible for coverage under the State child health plan.''.

(h) Clause (i) of subparagraph (C) of section 513(b)(2) of the Social Security Act, as added by section 2953 of this Act, is amended to read as follows:

''(i) Healthy relationships, including marriage and family interactions.''.

(i) Section 1115 of the Social Security Act (42 U.S.C. 1315) is amended by inserting after subsection (c) the following:

''(d)(1) An application or renewal of any experimental, pilot, or demonstration project undertaken under subsection (a) to promote the objectives of title XIX or XXI in a State that would result in an impact on eligibility, enrollment, benefits, cost-sharing, or financing with respect to a State program under title XIX or XXI (in this subsection referred to as a 'demonstration project') shall be considered by the Secretary in accordance with the regulations required to be promulgated under paragraph (2).

''(2) Not later than 180 days after the date of enactment of this subsection, the Secretary shall promulgate regulations relating to applications for, and renewals of, a demonstration project that provide for—

''(A) a process for public notice and comment at the State level, including public hearings, sufficient to ensure a meaningful level of public input;

''(B) requirements relating to—

''(i) the goals of the program to be implemented or renewed under the demonstration project;

''(ii) the expected State and Federal costs and coverage projections of the demonstration project; and

''(iii) the specific plans of the State to ensure that the demonstration project will be in compliance with title XIX or XXI;

''(C) 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;

''(D) a process for the submission to the Secretary of periodic reports by the State concerning the implementation of the demonstration project; and

''(E) a process for the periodic evaluation by the Secretary of the demonstration project.

''(3) The Secretary shall annually report to Congress concerning actions taken by the Secretary with respect to applications for demonstration projects under this section.''.

(j) Subtitle F of title III of this Act is amended by adding at the end the following:

''SEC. 3512. GAO STUDY AND REPORT ON CAUSES OF ACTION.

''(a) STUDY.—

''(1) IN GENERAL.—The Comptroller General of the United States shall conduct a study of whether the development, recognition, or implementation of any guideline or other standards under a provision described in paragraph (2) would result in the establishment of a new cause of action or claim.

''(2) PROVISIONS DESCRIBED.—The provisions described in this paragraph include the following:

''(A) Section 2701 (adult health quality measures).

''(B) Section 2702 (payment adjustments for health care acquired conditions).

''(C) Section 3001 (Hospital Value-Based Purchase Program).

''(D) Section 3002 (improvements to the Physician Quality Reporting Initiative).

''(E) Section 3003 (improvements to the Physician Feedback Program).

''(F) Section 3007 (value based payment modifier under physician fee schedule).

''(G) Section 3008 (payment adjustment for conditions acquired in hospitals).

''(H) Section 3013 (quality measure development).

''(I) Section 3014 (quality measurement).

''(J) Section 3021 (Establishment of Center for Medicare and Medicaid Innovation).

''(K) Section 3025 (hospital readmission reduction program).

''(L) Section 3501 (health care delivery system research, quality improvement).

''(M) Section 4003 (Task Force on Clinical and Preventive Services).

''(N) Section 4301 (research to optimize deliver of public health services).

''(b) REPORT.—Not later than 2 years after the date of enactment of this Act, the Comptroller General of the United States shall submit to the appropriate committees of Congress, a report containing the findings made by the Comptroller General under the study under subsection (a).''.

SEC. 10202. INCENTIVES FOR STATES TO OFFER HOME AND COMMUNITY-BASED SERVICES AS A LONG-TERM CARE ALTERNATIVE TO NURSING HOMES.

(a) STATE BALANCING INCENTIVE PAYMENTS PROGRAM.—Notwithstanding section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)), in the case of a balancing incentive payment State, as defined in subsection (b), that meets the conditions described in subsection (c), during the balancing incentive period, the Federal medical assistance percentage determined for the State under section 1905(b) of such Act and, if applicable, increased under subsection (z) or (aa) shall be increased by the applicable percentage points determined under subsection (d) with respect to eligible medical assistance expenditures described in subsection (e).

(b) BALANCING INCENTIVE PAYMENT STATE.—A balancing incentive payment State is a State—

(1) in which less than 50 percent of the total expenditures for medical assistance under the State Medicaid program for a fiscal year for long-term services and supports (as defined by the Secretary under subsection (f))(1)) are for non-institutionally-based long-term services and supports described in subsection (f)(1)(B);

(2) that submits an application and meets the conditions described in subsection (c); and

(3) that is selected by the Secretary to participate in the State balancing incentive payment program established under this section.

(c) CONDITIONS.—The conditions described in this subsection are the following:

(1) APPLICATION.—The State submits an application to the Secretary that includes, in addition to such other information as the Secretary shall require—

(A) a proposed budget that details the State's plan to expand and diversify medical assistance for non-institutionally-based long-term services and supports described in subsection (f)(1)(B) under the State Medicaid program during the balancing incentive period and achieve the target spending percentage applicable to the State under paragraph (2), including through structural changes to how the State furnishes such assistance, such as through the establishment of a ''no wrong door - single entry point system'', optional presumptive eligibility, case management services, and the use of core standardized assessment instruments, and that includes a description of the new or expanded offerings of such services that the State will provide and the projected costs of such services; and

(B) in the case of a State that proposes to expand the provision of home and community-based services under its State Medicaid program through a State plan amendment under section 1915(i) of the Social Security Act, at the option of the State, an election to increase the income eligibility for such services from 150 percent of the poverty line to such higher percentage as the State may establish for such purpose, not to exceed 300 percent of the supplemental security income benefit rate established by section 1611(b)(1) of the Social Security Act (42 U.S.C. 1382(b)(1)).

(2) TARGET SPENDING PERCENTAGES.—

(A) In the case of a balancing incentive payment State in which less than 25 percent of the total expenditures for long-term services and supports under the State Medicaid program for fiscal year 2009 are for home and community-based services, the target spending percentage for the State to achieve by not later than October 1, 2015, is that 25 percent of the total expenditures for long-term services and supports under the State Medicaid program are for home and community-based services.

(B) In the case of any other balancing incentive payment State, the target spending percentage for the State to achieve by not later than October 1, 2015, is that 50 percent of the total expenditures for long-term services and supports under the State Medicaid program are for home and community-based services.

(3) MAINTENANCE OF ELIGIBILITY REQUIREMENTS.—The State does not apply eligibility standards, methodologies, or procedures for determining eligibility for medical assistance for non-institutionally-based long-term services and supports described in subsection (f)(1)(B) under the State Medicaid program that are more restrictive than the eligibility standards, methodologies, or procedures in effect for such purposes on December 31, 2010.

(4) USE OF ADDITIONAL FUNDS.—The State agrees to use the additional Federal funds paid to the State as a result of this section only for purposes of providing new or expanded offerings of non-institutionally-based long-term services and supports described in subsection (f)(1)(B) under the State Medicaid program.

(5) STRUCTURAL CHANGES.—The State agrees to make, not later than the end of the 6-month period that begins on the date the State submits an application under this section, the following changes:

(A) ''NO WRONG DOOR - SINGLE ENTRY POINT SYSTEM''.—Development of a statewide system to enable consumers to access all long-term services and supports through an agency, organization, coordinated network, or portal, in accordance with such standards as the State shall establish and that shall provide information regarding the availability

of such services, how to apply for such services, referral services for services and supports otherwise available in the community, and determinations of financial and functional eligibility for such services and supports, or assistance with assessment processes for financial and functional eligibility.

(B) CONFLICT-FREE CASE MANAGEMENT SERVICES.—Conflict-free case management services to develop a service plan, arrange for services and supports, support the beneficiary (and, if appropriate, the beneficiary's caregivers) in directing the provision of services and supports for the beneficiary, and conduct ongoing monitoring to assure that services and supports are delivered to meet the beneficiary's needs and achieve intended outcomes.

(C) CORE STANDARDIZED ASSESSMENT INSTRUMENTS.—Development of core standardized assessment instruments for determining eligibility for non-institutionally-based long-term services and supports described in subsection (f)(1)(B), which shall be used in a uniform manner throughout the State, to determine a beneficiary's needs for training, support services, medical care, transportation, and other services, and develop an individual service plan to address such needs.

(6) DATA COLLECTION.—The State agrees to collect from providers of services and through such other means as the State determines appropriate the following data:

(A) SERVICES DATA.—Services data from providers of non-institutionally-based long-term services and supports described in subsection (f)(1)(B) on a per-beneficiary basis and in accordance with such standardized coding procedures as the State shall establish in consultation with the Secretary.

(B) QUALITY DATA.—Quality data on a selected set of core quality measures agreed upon by the Secretary and the State that are linked to population-specific outcomes measures and accessible to providers.

(C) OUTCOMES MEASURES.—Outcomes measures data on a selected set of core population-specific outcomes measures agreed upon by the Secretary and the State that are accessible to providers and include—

(i) measures of beneficiary and family caregiver experience with providers;

(ii) measures of beneficiary and family caregiver satisfaction with services; and

(iii) measures for achieving desired outcomes appropriate to a specific beneficiary, including employment, participation in community life, health stability, and prevention of loss in function.

(d) APPLICABLE PERCENTAGE POINTS INCREASE IN FMAP.—The applicable percentage points increase is—

(1) in the case of a balancing incentive payment State subject to the target spending percentage described in subsection (c)(2)(A), 5 percentage points; and

(2) in the case of any other balancing incentive payment State, 2 percentage points.

(e) ELIGIBLE MEDICAL ASSISTANCE EXPENDITURES.—

(1) IN GENERAL.—Subject to paragraph (2), medical assistance described in this subsection is medical assistance for non-institutionally-based long-term services and supports described in subsection (f)(1)(B) that is provided by a balancing incentive payment State under its State Medicaid program during the balancing incentive payment period.

(2) LIMITATION ON PAYMENTS.—In no case may the aggregate amount of payments made by the Secretary to balancing incentive payment States under this section during the balancing incentive period exceed $3,000,000,000.

(f) DEFINITIONS.—In this section:

(1) LONG-TERM SERVICES AND SUPPORTS DEFINED.—The term ''long-term services and supports'' has the meaning given that term by Secretary and may include any of the following (as defined for purposes of State Medicaid programs):

(A) INSTITUTIONALLY-BASED LONG-TERM SERVICES AND SUPPORTS.—Services provided in an institution, including the following:

(i) Nursing facility services.

(ii) Services in an intermediate care facility for the mentally retarded described in subsection (a)(15) of section 1905 of such Act.

(B) NON-INSTITUTIONALLY-BASED LONG-TERM SERVICES AND SUPPORTS.—Services not provided in an institution, including the following:

(i) Home and community-based services provided under subsection (c), (d), or (i) of section 1915 of such Act or under a waiver under section 1115 of such Act.

(ii) Home health care services.

(iii) Personal care services.

(iv) Services described in subsection (a)(26) of section 1905 of such Act (relating to PACE program services).

(v) Self-directed personal assistance services described in section 1915(j) of such Act.

(2) BALANCING INCENTIVE PERIOD.—The term ''balancing incentive period'' means the period that begins on October 1, 2011, and ends on September 30, 2015.

(3) POVERTY LINE.—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)).

(4) STATE MEDICAID PROGRAM.—The term ''State Medicaid program'' means the State program for medical assistance provided under a State plan under title XIX of the Social Security Act and under any waiver approved with respect to such State plan.

SEC. 10203. EXTENSION OF FUNDING FOR CHIP THROUGH FISCAL YEAR 2015 AND OTHER CHIP-RELATED PROVISIONS.

(a) Section 1311(c)(1) of this Act is amended by striking ''and'' at the end of subparagraph (G), by striking the period at the end of subparagraph (H) and inserting ''; and'', and by adding at the end the following:

''(I) report to the Secretary at least annually and in such manner as the Secretary shall require, pediatric quality reporting measures consistent with the pediatric quality reporting measures established under section 1139A of the Social Security Act.''.

(b) Effective as if included in the enactment of the Children's Health Insurance Program Reauthorization Act of 2009 (Public Law 111–3):

(1) Section 1906(e)(2) of the Social Security Act (42 U.S.C. 1396e(e)(2)) is amended by striking ''means'' and all that follows through the period and inserting ''has the meaning given that term in section 2105(c)(3)(A).''.

(2)(A) Section 1906A(a) of the Social Security Act (42 U.S.C. 1396e–1(a)), is amended by inserting before the period the following: ''and the offering of such a subsidy is cost-effective, as defined for purposes of section 2105(c)(3)(A)''.

(B) This Act shall be applied without regard to subparagraph (A) of section 2003(a)(1) of this Act and that subparagraph and the amendment made by that subparagraph are hereby deemed null, void, and of no effect.

(3) Section 2105(c)(10) of the Social Security Act (42 U.S.C. 1397ee(c)(10)) is amended—

(A) in subparagraph (A), in the first sentence, by inserting before the period the following: ''if the offering of such a subsidy is cost-effective, as defined for purposes of paragraph (3)(A)'';

(B) by striking subparagraph (M); and

(C) by redesignating subparagraph (N) as subparagraph (M).

(4) Section 2105(c)(3)(A) of the Social Security Act (42 U.S.C. 1397ee(c)(3)(A)) is amended—

(A) in the matter preceding clause (i), by striking ''to'' and inserting ''to—''; and

(B) in clause (ii), by striking the period and inserting a semicolon.

(c) Section 2105 of the Social Security Act (42 U.S.C. 1397ee), as amended by section 2101, is amended—

(1) in subsection (b), in the second sentence, by striking ''2013'' and inserting ''2015''; and

(2) in subsection (d)(3)—

(A) in subparagraph (A)—

(i) in the first sentence, by inserting ''as a condition of receiving payments under section 1903(a),'' after ''2019,'';

(ii) in clause (i), by striking ''or'' at the end;

(iii) by redesignating clause (ii) as clause (iii); and

(iv) by inserting after clause (i), the following:

''(ii) after September 30, 2015, enrolling children eligible to be targeted low-income children under the State child health plan in a qualified health plan that has been certified by the Secretary under subparagraph (C); or'';

(B) in subparagraph (B), by striking ''provided coverage'' and inserting ''screened for eligibility for medical assistance under the State plan under title XIX or a waiver of that plan and, if found eligible, enrolled in such plan or a waiver. In the case of such children who, as a result of such screening, are determined to not be eligible for medical assistance under the State plan or a waiver under title XIX, the State shall establish procedures to ensure that the children are enrolled in a qualified health plan that has been certified by the Secretary under subparagraph (C) and is offered''; and

(C) by adding at the end the following:

''(C) CERTIFICATION OF COMPARABILITY OF PEDIATRIC COVERAGE OFFERED BY QUALIFIED HEALTH PLANS.—With respect to each State, the Secretary, not later than April 1, 2015, shall review the benefits offered for children and the cost-sharing imposed with respect to such benefits by qualified health plans offered through an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act and shall certify those plans that offer benefits for children and impose cost-sharing with respect to such benefits that the Secretary determines are at least comparable to the benefits offered and cost-sharing protections provided under the State child health plan.''.

(d)(1) Section 2104(a) of such Act (42 U.S.C. 1397dd(a)) is amended—

(A) in paragraph (15), by striking ''and'' at the end; and

(B) by striking paragraph (16) and inserting the following:

''(16) for fiscal year 2013, $17,406,000,000;

''(17) for fiscal year 2014, $19,147,000,000; and

''(18) for fiscal year 2015, for purposes of making 2 semi-annual allotments—

''(A) $2,850,000,000 for the period beginning on October 1, 2014, and ending on March 31, 2015, and

''(B) $2,850,000,000 for the period beginning on April 1, 2015, and ending on September 30, 2015.''.

(2)(A) Section 2104(m) of such Act (42 U.S.C. 1397dd(m)), as amended by section 2102(a)(1), is amended—

(i) in the subsection heading, by striking ''2013'' and inserting ''2015'';

(ii) in paragraph (2)—

(I) in the paragraph heading, by striking ''2012'' and inserting ''2014''; and

(II) by adding at the end the following:

''(B) FISCAL YEARS 2013 AND 2014.—Subject to paragraphs (4) and (6), from the amount made available under paragraphs (16) and (17) of subsection (a) for fiscal years 2013 and

2014, respectively, the Secretary shall compute a State allotment for each State (including the District of Columbia and each commonwealth and territory) for each such fiscal year as follows:

''(i) REBASING IN FISCAL YEAR 2013.—For fiscal year 2013, the allotment of the State is equal to the Federal payments to the State that are attributable to (and countable towards) the total amount of allotments available under this section to the State in fiscal year 2012 (including payments made to the State under subsection (n) for fiscal year 2012 as well as amounts redistributed to the State in fiscal year 2012), multiplied by the allotment increase factor under paragraph (5) for fiscal year 2013.

''(ii) GROWTH FACTOR UPDATE FOR FISCAL YEAR 2014.—For fiscal year 2014, the allotment of the State is equal to the sum of—

''(I) the amount of the State allotment under clause (i) for fiscal year 2013; and

''(II) the amount of any payments made to the State under subsection (n) for fiscal year 2013,

multiplied by the allotment increase factor under paragraph (5) for fiscal year 2014.'';

(iii) in paragraph (3)—

(I) in the paragraph heading, by striking ''2013'' and inserting ''2015'';

(II) in subparagraphs (A) and (B), by striking ''paragraph (16)'' each place it appears and inserting ''paragraph (18)'';

(III) in subparagraph (C)—

(aa) by striking ''2012'' each place it appears and inserting ''2014''; and

(bb) by striking ''2013'' and inserting ''2015''; and

(IV) in subparagraph (D)—

(aa) in clause (i)(I), by striking ''subsection (a)(16)(A)'' and inserting ''subsection (a)(18)(A)''; and

(bb) in clause (ii)(II), by striking ''subsection (a)(16)(B)'' and inserting ''subsection (a)(18)(B)'';

(iv) in paragraph (4), by striking ''2013'' and inserting ''2015'';

(v) in paragraph (6)—

(I) in subparagraph (A), by striking ''2013'' and inserting ''2015''; and

(II) in the flush language after and below subparagraph (B)(ii), by striking ''or fiscal year 2012'' and inserting '', fiscal year 2012, or fiscal year 2014''; and

(vi) in paragraph (8)—

(I) in the paragraph heading, by striking ''2013'' and inserting ''2015''; and

(II) by striking ''2013'' and inserting ''2015''.

(B) Section 2104(n) of such Act (42 U.S.C. 1397dd(n)) is amended—

(i) in paragraph (2)—

(I) in subparagraph (A)(ii)—

(aa) by striking ''2012'' and inserting ''2014''; and

(bb) by striking ''2013'' and inserting ''2015'';

(II) in subparagraph (B)—

(aa) by striking ''2012'' and inserting ''2014''; and

(bb) by striking ''2013'' and inserting ''2015''; and

(ii) in paragraph (3)(A), by striking ''or a semi-annual allotment period for fiscal year 2013'' and inserting ''fiscal year 2013, fiscal year 2014, or a semi-annual allotment period for fiscal year 2015''.

(C) Section 2105(g)(4) of such Act (42 U.S.C. 1397ee(g)(4)) is amended—

(i) in the paragraph heading, by striking ''2013'' and inserting ''2015''; and

(ii) in subparagraph (A), by striking ''2013'' and inserting ''2015''.

(D) Section 2110(b) of such Act (42 U.S.C. 1397jj(b)) is amended—

(i) in paragraph (2)(B), by inserting ''except as provided in paragraph (6),'' before ''a child''; and

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

''(6) EXCEPTIONS TO EXCLUSION OF CHILDREN OF EMPLOYEES OF A PUBLIC AGENCY IN THE STATE.—

''(A) IN GENERAL.—A child shall not be considered to be described in paragraph (2)(B) if—

''(i) the public agency that employs a member of the child's family to which such paragraph applies satisfies subparagraph (B); or

''(ii) subparagraph (C) applies to such child.

''(B) MAINTENANCE OF EFFORT WITH RESPECT TO PER PERSON AGENCY CONTRIBUTION FOR FAMILY COVERAGE.—For purposes of subparagraph (A)(i), a public agency satisfies this subparagraph if the amount of annual agency expenditures made on behalf of each employee enrolled in health coverage paid for by the agency that includes dependent coverage for the most recent State fiscal year is not less than the amount of such expenditures made by the agency for the 1997 State fiscal year, increased by the percentage increase in the medical care expenditure category of the Consumer Price Index for All-Urban Consumers (all items: U.S. City Average) for such preceding fiscal year.

''(C) HARDSHIP EXCEPTION.—For purposes of subparagraph (A)(ii), this subparagraph applies to a child if the State determines, on a case-by-case basis, that the annual aggregate amount of premiums and cost-sharing imposed for coverage of the family of the child would exceed 5 percent of such family's income for the year involved.''.

(E) Section 2113 of such Act (42 U.S.C. 1397mm) is amended—

(i) in subsection (a)(1), by striking ''2013'' and inserting ''2015''; and

(ii) in subsection (g), by striking ''$100,000,000 for the period of fiscal years 2009 through 2013'' and inserting ''$140,000,000 for the period of fiscal years 2009 through 2015''.

(F) Section 108 of Public Law 111–3 is amended by striking ''$11,706,000,000'' and all that follows through the second sentence and inserting ''$15,361,000,000 to accompany the allotment made for the period beginning on October 1, 2014, and ending on March 31, 2015, under section 2104(a)(18)(A) of the Social Security Act (42 U.S.C. 1397dd(a)(18)(A)), to remain available until expended. Such amount shall be used to provide allotments to States under paragraph (3) of section 2104(m) of the Social Security Act (42 U.S.C. 1397dd(m)) for the first 6 months of fiscal year 2015 in the same manner as allotments are provided under subsection (a)(18)(A) of such section 2104 and subject to the same terms and conditions as apply to the allotments provided from such subsection (a)(18)(A).''.

PART II—SUPPORT FOR PREGNANT AND PARENTING TEENS AND WOMEN

SEC. 10211. DEFINITIONS.

In this part:

(1) ACCOMPANIMENT.—The term ''accompaniment'' means assisting, representing, and accompanying a woman in seeking judicial relief for child support, child custody, restraining orders, and restitution for harm to persons and property, and in filing criminal charges, and may include the payment of court costs and reasonable attorney and witness fees associated therewith.

(2) ELIGIBLE INSTITUTION OF HIGHER EDUCATION.—The term ''eligible institution of higher education'' means an institution of higher education (as such term is defined in section 101 of the Higher Education Act of 1965 (20 U.S.C. 1001)) that has established and operates, or agrees to establish and operate upon the receipt of a grant under this part, a pregnant and parenting student services office.

(3) COMMUNITY SERVICE CENTER.—The term ''community service center'' means a nonprofit organization that provides social services to residents of a specific geographical area via direct service or by contract with a local governmental agency.

(4) HIGH SCHOOL.—The term ''high school'' means any public or private school that operates grades 10 through 12, inclusive, grades 9 through 12, inclusive or grades 7 through 12, inclusive.

(5) INTERVENTION SERVICES.—The term ''intervention services'' means, with respect to domestic violence, sexual violence, sexual assault, or stalking, 24-hour telephone hotline services for police protection and referral to shelters.

(6) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(7) STATE.—The term ''State'' includes the District of Columbia, any commonwealth, possession, or other territory of the United States, and any Indian tribe or reservation.

(8) SUPPORTIVE SOCIAL SERVICES.—The term ''supportive social services'' means transitional and permanent housing, vocational counseling, and individual and group counseling aimed at preventing domestic violence, sexual violence, sexual assault, or stalking.

(9) VIOLENCE.—The term ''violence'' means actual violence and the risk or threat of violence.

SEC. 10212. ESTABLISHMENT OF PREGNANCY ASSISTANCE FUND.

(a) IN GENERAL.—The Secretary, in collaboration and coordination with the Secretary of Education (as appropriate), shall establish a Pregnancy Assistance Fund to be administered by the Secretary, for the purpose of awarding competitive grants to States to assist pregnant and parenting teens and women.

(b) USE OF FUND.—A State may apply for a grant under subsection (a) to carry out any activities provided for in section 10213.

(c) APPLICATIONS.—To be eligible to receive a grant under subsection (a), a State shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including a description of the purposes for which the grant is being requested and the designation of a State agency for receipt and administration of funding received under this part.

SEC. 10213. PERMISSIBLE USES OF FUND.

(a) IN GENERAL.—A State shall use amounts received under a grant under section 10212 for the purposes described in this section to assist pregnant and parenting teens and women.

(b) INSTITUTIONS OF HIGHER EDUCATION.—

(1) IN GENERAL.—A State may use amounts received under a grant under section 10212 to make funding available to eligible institutions of higher education to enable the eligible institutions to establish, maintain, or operate pregnant and parenting student services. Such funding shall be used to supplement, not supplant, existing funding for such services.

(2) APPLICATION.—An eligible institution of higher education that desires to receive funding under this subsection shall submit an application to the designated State agency at such time, in such manner, and containing such information as the State agency may require.

(3) MATCHING REQUIREMENT.—An eligible institution of higher education that receives funding under this subsection shall contribute to the conduct of the pregnant and parenting student services office supported by the funding an amount from non-Federal funds equal to 25 percent of the amount of

the funding provided. The non-Federal share may be in cash or in-kind, fairly evaluated, including services, facilities, supplies, or equipment.

(4) USE OF FUNDS FOR ASSISTING PREGNANT AND PARENTING COLLEGE STUDENTS.—An eligible institution of higher education that receives funding under this subsection shall use such funds to establish, maintain or operate pregnant and parenting student services and may use such funding for the following programs and activities:

(A) Conduct a needs assessment on campus and within the local community—

(i) to assess pregnancy and parenting resources, located on the campus or within the local community, that are available to meet the needs described in subparagraph (B); and

(ii) to set goals for—

(I) improving such resources for pregnant, parenting, and prospective parenting students; and

(II) improving access to such resources.

(B) Annually assess the performance of the eligible institution in meeting the following needs of students enrolled in the eligible institution who are pregnant or are parents:

(i) The inclusion of maternity coverage and the availability of riders for additional family members in student health care.

(ii) Family housing.

(iii) Child care.

(iv) Flexible or alternative academic scheduling, such as telecommuting programs, to enable pregnant or parenting students to continue their education or stay in school.

(v) Education to improve parenting skills for mothers and fathers and to strengthen marriages.

(vi) Maternity and baby clothing, baby food (including formula), baby furniture, and similar items to assist parents and prospective parents in meeting the material needs of their children.

(vii) Post-partum counseling.

(C) Identify public and private service providers, located on the campus of the eligible institution or within the local community, that are qualified to meet the needs described in subparagraph (B), and establishes programs with qualified providers to meet such needs.

(D) Assist pregnant and parenting students, fathers or spouses in locating and obtaining services that meet the needs described in subparagraph (B).

(E) If appropriate, provide referrals for prenatal care and delivery, infant or foster care, or adoption, to a student who requests such information. An office shall make such referrals only to service providers that serve the following types of individuals:

(i) Parents.

(ii) Prospective parents awaiting adoption.

(iii) Women who are pregnant and plan on parenting or placing the child for adoption.

(iv) Parenting or prospective parenting couples.

(5) REPORTING.—

(A) ANNUAL REPORT BY INSTITUTIONS.—

(i) IN GENERAL.—For each fiscal year that an eligible institution of higher education receives funds under this subsection, the eligible institution shall prepare and submit to the State, by the date determined by the State, a report that—

(I) itemizes the pregnant and parenting student services office's expenditures for the fiscal year;

(II) contains a review and evaluation of the performance of the office in fulfilling the requirements of this section, using the specific performance criteria or standards established under subparagraph (B)(i); and

(III) describes the achievement of the office in meeting the needs listed in paragraph (4)(B) of the students served by the eligible institution, and the frequency of use of the office by such students.

(ii) PERFORMANCE CRITERIA.—Not later than 180 days before the date the annual report described in clause (i) is submitted, the State—

(I) shall identify the specific performance criteria or standards that shall be used to prepare the report; and

(II) may establish the form or format of the report.

(B) REPORT BY STATE.—The State shall annually prepare and submit a report on the findings under this subsection, including the number of eligible institutions of higher education that were awarded funds and the number of students served by each pregnant and parenting student services office receiving funds under this section, to the Secretary.

(c) SUPPORT FOR PREGNANT AND PARENTING TEENS.—A State may use amounts received under a grant under section 10212 to make funding available to eligible high schools and community service centers to establish, maintain or operate pregnant and parenting services in the same general manner and in accordance with all conditions and requirements described in subsection (b), except that paragraph (3) of such subsection shall not apply for purposes of this subsection.

(d) IMPROVING SERVICES FOR PREGNANT WOMEN WHO ARE VICTIMS OF DOMESTIC VIOLENCE, SEXUAL VIOLENCE, SEXUAL ASSAULT, AND STALKING.—

(1) IN GENERAL.—A State may use amounts received under a grant under section 10212 to make funding available tp its State Attorney General to assist Statewide offices in providing—

(A) intervention services, accompaniment, and supportive social services for eligible pregnant women who are victims of domestic violence, sexual violence, sexual assault, or stalking.

(B) technical assistance and training (as described in subsection (c)) relating to violence against eligible pregnant women to be made available to the following:

(i) Federal, State, tribal, territorial, and local governments, law enforcement agencies, and courts.

(ii) Professionals working in legal, social service, and health care settings.

(iii) Nonprofit organizations.

(iv) Faith-based organizations.

(2) ELIGIBILITY.—To be eligible for a grant under paragraph (1), a State Attorney General shall submit an application to the designated State agency at such time, in such manner, and containing such information, as specified by the State.

(3) TECHNICAL ASSISTANCE AND TRAINING DESCRIBED.—For purposes of paragraph (1)(B), technical assistance and training is—

(A) the identification of eligible pregnant women experiencing domestic violence, sexual violence, sexual assault, or stalking;

(B) the assessment of the immediate and short-term safety of such a pregnant woman, the evaluation of the impact of the violence or stalking on the pregnant woman's health, and the assistance of the pregnant woman in developing a plan aimed at preventing further domestic violence, sexual violence, sexual assault, or stalking, as appropriate;

(C) the maintenance of complete medical or forensic records that include the documentation of any examination, treatment given, and referrals made, recording the location and nature of the pregnant woman's injuries, and the establishment of mechanisms to ensure the privacy and confidentiality of those medical records; and

(D) the identification and referral of the pregnant woman to appropriate public and private nonprofit entities that provide intervention services, accompaniment, and supportive social services.

(4) ELIGIBLE PREGNANT WOMAN.—In this subsection, the term ''eligible pregnant woman'' means any woman who is pregnant on the date on which such woman becomes a victim of domestic violence, sexual violence, sexual assault, or stalking or who was pregnant during the one-year period before such date.

(e) PUBLIC AWARENESS AND EDUCATION.—A State may use amounts received under a grant under section 10212 to make funding available to increase public awareness and education concerning any services available to pregnant and parenting teens and women under this part, or any other resources available to pregnant and parenting women in keeping with the intent and purposes of this part. The State shall be responsible for setting guidelines or limits as to how much of funding may be utilized for public awareness and education in any funding award.

SEC. 10214. APPROPRIATIONS.

There is authorized to be appropriated, and there are appropriated, $25,000,000 for each of fiscal years 2010 through 2019, to carry out this part.

PART III—INDIAN HEALTH CARE IMPROVEMENT

SEC. 10221. INDIAN HEALTH CARE IMPROVEMENT.

(a) IN GENERAL.—Except as provided in subsection (b), S. 1790 entitled ''A bill to amend the Indian Health Care Improvement Act to revise and extend that Act, and for other purposes.'', as reported by the Committee on Indian Affairs of the Senate in December 2009, is enacted into law.

(b) AMENDMENTS.—

(1) Section 119 of the Indian Health Care Improvement Act (as amended by section 111 of the bill referred to in subsection (a)) is amended—

(A) in subsection (d)—

(i) in paragraph (2), by striking ''In establishing'' and inserting ''Subject to paragraphs (3) and (4), in establishing''; and

(ii) by adding at the end the following:

''(3) ELECTION OF INDIAN TRIBE OR TRIBAL ORGANIZATION.—

''(A) IN GENERAL.—Subparagraph (B) of paragraph (2) shall not apply in the case of an election made by an Indian tribe or tribal organization located in a State (other than Alaska) in which the use of dental health aide therapist services or midlevel dental health provider services is authorized under State law to supply such services in accordance with State law.

''(B) ACTION BY SECRETARY.—On an election by an Indian tribe or tribal organization under subparagraph (A), the Secretary, acting through the Service, shall facilitate implementation of the services elected.

''(4) VACANCIES.—The Secretary shall not fill any vacancy for a certified dentist in a program operated by the Service with a dental health aide therapist.''; and

(B) by adding at the end the following:

''(e) EFFECT OF SECTION.—Nothing in this section shall restrict the ability of the Service, an Indian tribe, or a tribal organization to participate in any program or to provide any service authorized by any other Federal law.''.

(2) The Indian Health Care Improvement Act (as amended by section 134(b) of the bill referred to in subsection (a)) is amended by striking section 125 (relating to treatment of scholarships for certain purposes).

(3) Section 806 of the Indian Health Care Improvement Act (25 U.S.C. 1676) is amended—

(A) by striking ''Any limitation'' and inserting the following:

''(a) HHS APPROPRIATIONS.—Any limitation''; and

(B) by adding at the end the following:

''(b) LIMITATIONS PURSUANT TO OTHER FEDERAL LAW.—Any limitation pursuant to other Federal laws on the use of Federal funds appropriated to the Service shall apply with respect to the performance or coverage of abortions.''.

(4) The bill referred to in subsection (a) is amended by striking section 201.

Subtitle C—Provisions Relating to Title III

SEC. 10301. PLANS FOR A VALUE-BASED PURCHASING PROGRAM FOR AMBULATORY SURGICAL CENTERS.

(a) IN GENERAL.—Section 3006 is amended by adding at the end the following new subsection:

''(f) AMBULATORY SURGICAL CENTERS.—

''(1) IN GENERAL.—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 ambulatory surgical centers (as described in section 1833(i) of the Social Security Act (42 U.S.C. 13951(i))).

''(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 of such Act, as added by section 3014), to the extent feasible and practicable, of all dimensions of quality and efficiency in ambulatory surgical centers.

''(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 ambulatory surgical centers.

''(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 January 1, 2011, the Secretary shall submit to Congress a report containing the plan developed under paragraph (1).''.

(b) TECHNICAL.—Section 3006(a)(2)(A) is amended by striking clauses (i) and (ii).

SEC. 10302. REVISION TO NATIONAL STRATEGY FOR QUALITY IMPROVEMENT IN HEALTH CARE.

Section 399HH(a)(2)(B)(iii) of the Public Health Service Act, as added by section 3011, is amended by inserting ''(taking into consideration the limitations set forth in subsections (c) and (d) of section 1182 of the Social Security Act)'' after ''information''.

SEC. 10303. DEVELOPMENT OF OUTCOME MEASURES.

(a) DEVELOPMENT.—Section 931 of the Public Health Service Act, as added by section 3013(a), is amended by adding at the end the following new subsection:

''(f) DEVELOPMENT OF OUTCOME MEASURES.—

''(1) IN GENERAL.—The Secretary shall develop, and periodically update (not less than every 3 years), provider-level outcome measures for hospitals and physicians, as well as other providers as determined appropriate by the Secretary.

''(2) CATEGORIES OF MEASURES.—The measures developed under this subsection shall include, to the extent determined appropriate by the Secretary—

''(A) outcome measurement for acute and chronic diseases, including, to the extent feasible, the 5 most prevalent and resource-intensive acute and chronic medical conditions; and

''(B) outcome measurement for primary and preventative care, including, to the extent feasible, measurements that cover provision of such care for distinct patient populations (such as healthy children, chronically ill adults, or infirm elderly individuals).

''(3) GOALS.—In developing such measures, the Secretary shall seek to—

''(A) address issues regarding risk adjustment, accountability, and sample size;

''(B) include the full scope of services that comprise a cycle of care; and

''(C) include multiple dimensions.

''(4) TIMEFRAME.—

''(A) ACUTE AND CHRONIC DISEASES.—Not later than 24 months after the date of enactment of this Act, the Secretary shall develop not less than 10 measures described in paragraph (2)(A).

''(B) PRIMARY AND PREVENTIVE CARE.—Not later than 36 months after the date of enactment of this Act, the Secretary shall develop not less than 10 measures described in paragraph (2)(B).''.

(b) HOSPITAL-ACQUIRED CONDITIONS.—Section 1890A of the Social Security Act, as amended by section 3013(b), is amended by adding at the end the following new subsection:

''(f) HOSPITAL ACQUIRED CONDITIONS.—The Secretary shall, to the extent practicable, publicly report on measures for hospital-acquired conditions that are currently utilized by the Centers for Medicare & Medicaid Services for the adjustment of the amount of payment to hospitals based on rates of hospital-acquired infections.''.

(c) CLINICAL PRACTICE GUIDELINES.—Section 304(b) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275) is amended by adding at the end the following new paragraph:

''(4) IDENTIFICATION.—

''(A) IN GENERAL.—Following receipt of the report submitted under paragraph (2), and not less than every 3 years thereafter, the Secretary shall contract with the Institute to employ the results of the study performed under paragraph (1) and the best methods identified by the Institute for the purpose of identifying existing and new clinical practice guidelines that were developed using such best methods, including guidelines listed in the National Guideline Clearinghouse.

''(B) CONSULTATION.—In carrying out the identification process under subparagraph (A), the Secretary shall allow for consultation with professional societies, voluntary health care organizations, and expert panels.''.

SEC. 10304. SELECTION OF EFFICIENCY MEASURES.

Sections 1890(b)(7) and 1890A of the Social Security Act, as added by section 3014, are amended by striking ''quality'' each place it appears and inserting ''quality and efficiency''.

SEC. 10305. DATA COLLECTION; PUBLIC REPORTING.

Section 399II(a) of the Public Health Service Act, as added by section 3015, is amended to read as follows:

''(a) IN GENERAL.—

''(1) ESTABLISHMENT OF STRATEGIC FRAMEWORK.—The Secretary shall establish and implement an overall strategic framework to carry out the public reporting of performance information, as described in section 399JJ. Such strategic framework may include methods and related timelines for implementing nationally consistent data collection, data aggregation, and analysis methods.

''(2) COLLECTION AND AGGREGATION OF DATA.—The Secretary shall collect and aggregate consistent data on quality and resource use measures from information systems used to support health care delivery, and may award grants or contracts for this purpose. The Secretary shall align such collection and aggregation efforts with the requirements and assistance regarding the expansion of health information technology systems, the interoperability of such technology systems, and related standards that are in effect on the date of enactment of the Patient Protection and Affordable Care Act.

''(3) SCOPE.—The Secretary shall ensure that the data collection, data aggregation, and analysis systems described in paragraph (1) involve an increasingly broad range of patient populations, providers, and geographic areas over time.''.

SEC. 10306. IMPROVEMENTS UNDER THE CENTER FOR MEDICARE AND MEDICAID INNOVATION.

Section 1115A of the Social Security Act, as added by section 3021, is amended—

(1) in subsection (a), by inserting at the end the following new paragraph:

''(5) TESTING WITHIN CERTAIN GEOGRAPHIC AREAS.—For purposes of testing payment and service delivery models under this section, the Secretary may elect to limit testing of a model to certain geographic areas.'';

(2) in subsection (b)(2)—

(A) in subparagraph (A)—

(i) in the second sentence, by striking ''the preceding sentence may include'' and inserting ''this subparagraph may include, but are not limited to,''; and

(ii) by inserting after the first sentence the following new sentence: ''The Secretary shall focus on models expected to reduce program costs under the applicable title while preserving or enhancing the quality of care received by individuals receiving benefits under such title.'';

(B) in subparagraph (B), by adding at the end the following new clauses:

''(xix) Utilizing, in particular in entities located in medically underserved areas and facilities of the Indian Health Service (whether operated by such Service or by an Indian tribe or tribal organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act)), telehealth services—

''(I) in treating behavioral health issues (such as post-traumatic stress disorder) and stroke; and

''(II) to improve the capacity of non-medical providers and non-specialized medical providers to provide health services for patients with chronic complex conditions.

''(xx) Utilizing a diverse network of providers of services and suppliers to improve care coordination for applicable individuals described in subsection (a)(4)(A)(i) with 2 or more chronic conditions and a history of prior-year hospitalization through interventions developed under the Medicare Coordinated Care Demonstration Project under section 4016 of the Balanced Budget Act of 1997 (42 U.S.C. 1395b–1 note).''; and

(C) in subparagraph (C), by adding at the end the following new clause:

''(viii) Whether the model demonstrates effective linkage with other public sector or private sector payers.'';

(3) in subsection (b)(4), by adding at the end the following new subparagraph:

''(C) MEASURE SELECTION.—To the extent feasible, the Secretary shall select measures under this paragraph that reflect national priorities for quality improvement and patient-centered care consistent with the measures described in 1890(b)(7)(B).''; and

(4) in subsection (c)—

(A) in paragraph (1)(B), by striking ''care and reduce spending; and'' and inserting ''patient care without increasing spending;'';

(B) in paragraph (2), by striking ''reduce program spending under applicable titles.'' and inserting ''reduce (or would not result in any increase in) net program spending under applicable titles; and''; and

(C) by adding at the end the following:

''(3) the Secretary determines that such expansion would not deny or limit the coverage or provision of benefits under the applicable title for applicable individuals.

In determining which models or demonstration projects to expand under the preceding sentence, the Secretary shall focus on models and demonstration projects that improve the quality of patient care and reduce spending.''.

SEC. 10307. IMPROVEMENTS TO THE MEDICARE SHARED SAVINGS PROGRAM.

Section 1899 of the Social Security Act, as added by section 3022, is amended by adding at the end the following new subsections:

''(i) OPTION TO USE OTHER PAYMENT MODELS.—

''(1) IN GENERAL.—If the Secretary determines appropriate, the Secretary may use any of the payment models described in paragraph (2) or (3) for making payments under the program rather than the payment model described in subsection (d).

''(2) PARTIAL CAPITATION MODEL.—

''(A) IN GENERAL.—Subject to subparagraph (B), a model described in this paragraph is a partial capitation model in which an ACO is at financial risk for some, but not all, of the items and services covered under parts A and B, such as at risk for some or all physicians' services or all items and services under part B. The Secretary may limit a partial capitation model to ACOs that are highly integrated systems of care and to ACOs capable of bearing risk, as determined to be appropriate by the Secretary.

''(B) NO ADDITIONAL PROGRAM EXPENDITURES.—Payments to an ACO for items and services under this title for beneficiaries for a year under the partial capitation model shall be established in a manner that does not result in spending more for such ACO for such beneficiaries than would otherwise be expended for such ACO for such beneficiaries for such year if the model were not implemented, as estimated by the Secretary.

''(3) OTHER PAYMENT MODELS.—

''(A) IN GENERAL.—Subject to subparagraph (B), a model described in this paragraph is any payment model that the Secretary determines will improve the quality and efficiency of items and services furnished under this title.

''(B) NO ADDITIONAL PROGRAM EXPENDITURES.—Subparagraph (B) of paragraph (2) shall apply to a payment model under subparagraph (A) in a similar manner as such subparagraph (B) applies to the payment model under paragraph (2).

''(j) INVOLVEMENT IN PRIVATE PAYER AND OTHER THIRD PARTY ARRANGEMENTS.—The Secretary may give preference to ACOs who are participating in similar arrangements with other payers.

''(k) TREATMENT OF PHYSICIAN GROUP PRACTICE DEMONSTRATION.—During the period beginning on the date of the enactment of this section and ending on the date the program is established, the Secretary may enter into an agreement with an ACO under the demonstration under section 1866A, subject to rebasing and other modifications deemed appropriate by the Secretary.''.

SEC. 10308. REVISIONS TO NATIONAL PILOT PROGRAM ON PAYMENT BUNDLING.

(a) IN GENERAL.—Section 1866D of the Social Security Act, as added by section 3023, is amended—

(1) in paragraph (a)(2)(B), in the matter preceding clause (i), by striking ''8 conditions'' and inserting ''10 conditions'';

(2) by striking subsection (c)(1)(B) and inserting the following:

''(B) EXPANSION.—The Secretary may, at any point after January 1, 2016, expand the duration and scope of the pilot program, to the extent determined appropriate by the Secretary, if—

''(i) the Secretary determines that such expansion is expected to—

''(I) reduce spending under title XVIII of the Social Security Act without reducing the quality of care; or

''(II) improve the quality of care and reduce spending;

''(ii) the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that such expansion would reduce program spending under such title XVIII; and

''(iii) the Secretary determines that such expansion would not deny or limit the coverage or provision of benefits under this title for individuals.''; and

(3) by striking subsection (g) and inserting the following new subsection:

''(g) APPLICATION OF PILOT PROGRAM TO CONTINUING CARE HOSPITALS.—

''(1) IN GENERAL.—In conducting the pilot program, the Secretary shall apply the provisions of the program so as to separately pilot test the continuing care hospital model.

''(2) SPECIAL RULES.—In pilot testing the continuing care hospital model under paragraph (1), the following rules shall apply:

''(A) Such model shall be tested without the limitation to the conditions selected under subsection (a)(2)(B).

''(B) Notwithstanding subsection (a)(2)(D), an episode of care shall be defined as the full period that a patient stays in the continuing care hospital plus the first 30 days following discharge from such hospital.

''(3) CONTINUING CARE HOSPITAL DEFINED.—In this subsection, the term 'continuing care hospital' means an entity that has demonstrated the ability to meet patient care and patient safety standards and that provides under common management the medical and rehabilitation services provided in inpatient rehabilitation hospitals and units (as defined in section 1886(d)(1)(B)(ii)), long term care hospitals (as defined in section1886(d)(1)(B)(iv)(I)), and skilled nursing facilities (as defined in section 1819(a)) that are located in a hospital described in section 1886(d).''.

(b) TECHNICAL AMENDMENTS.—

(1) Section 3023 is amended by striking ''1886C'' and inserting ''1866C''.

(2) Title XVIII of the Social Security Act is amended by redesignating section 1866D, as added by section 3024, as section 1866E.

SEC. 10309. REVISIONS TO HOSPITAL READMISSIONS REDUCTION PROGRAM.

Section 1886(q)(1) of the Social Security Act, as added by section 3025, in the matter preceding subparagraph (A), is amended by striking ''the Secretary shall reduce the payments'' and all that follows through ''the product of'' and inserting ''the Secretary shall make payments (in addition to the payments described in paragraph (2)(A)(ii)) for such a discharge to such hospital under subsection (d) (or section 1814(b)(3), as the case may be) in an amount equal to the product of''.

SEC. 10310. REPEAL OF PHYSICIAN PAYMENT UPDATE.

The provisions of, and the amendment made by, section 3101 are repealed

SEC. 10311. REVISIONS TO 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)), as amended by section 3105(a), is further amended—

(1) in the matter preceding clause (i)—

(A) by striking ''2007, for'' and inserting ''2007, and for''; and

(B) by striking ''2010, and for such services furnished on or after April 1, 2010, and before January 1, 2011'' and inserting ''2011''; and

(2) in each of clauses (i) and (ii)—

(A) by striking '', and on or after April 1, 2010, and before January 1, 2011'' each place it appears; and

(B) by striking ''January 1, 2010'' and inserting ''January 1, 2011'' 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), as amended by section 3105(b), is further amended by striking ''December 31, 2009, and during the period beginning on April 1, 2010, and ending on January 1, 2011'' and inserting ''December 31, 2010''.

(c) SUPER RURAL AMBULANCE.—Section 1834(l)(12)(A) of the Social Security Act (42 U.S.C. 1395m(l)(12)(A)), as amended by section 3105(c), is further amended by striking ''2010, and on or after April 1, 2010, and before January 1, 2011'' and inserting ''2011''.

SEC. 10312. CERTAIN PAYMENT RULES FOR LONG-TERM CARE HOSPITAL SERVICES AND MORATORIUM ON THE ESTABLISHMENT OF CERTAIN HOSPITALS AND FACILITIES.

(a) 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) and section 3106(a) of this Act, is further amended by striking ''4-year period'' each place it appears and inserting ''5-year period''.

(b) MORATORIUM.—Section 114(d) of such Act (42 U.S.C. 1395ww note), as amended by section 3106(b) of this Act, in the matter preceding subparagraph (A), is amended by striking ''4-year period'' and inserting ''5-year period''.

SEC. 10313. REVISIONS TO THE EXTENSION FOR THE RURAL COMMUNITY HOSPITAL DEMONSTRATION PROGRAM.

(a) IN GENERAL.—Subsection (g) of section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2272), as added by section 3123(a) of this Act, is amended to read as follows:

''(g) FIVE-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 5-year period (in this section referred to as the '5-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 5-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 5-year extension period, not more than 30 rural community hospitals may participate in the demonstration program under this section.

''(4) 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—

''(A) shall provide for the continued participation of such rural community hospital in the demonstration program during the 5-year extension period unless the rural community hospital makes an election, in such form and manner as the Secretary may specify, to discontinue such participation; and

''(B) in calculating the amount of payment under subsection (b) to the rural community hospital for covered inpatient hospital services furnished by the hospital during such 5-year extension period, shall substitute, under paragraph (1)(A) of such subsection—

''(i) the reasonable costs of providing such services for discharges occurring in the first cost reporting period beginning on or after the first day of the 5-year extension period, for

''(ii) the reasonable costs of providing such services for discharges occurring in the first cost reporting period beginning on or after the implementation of the demonstration program.''.

(b) CONFORMING AMENDMENTS.—Subsection (a)(5) of section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2272), as amended by section 3123(b) of this Act, is amended by striking ''1-year extension'' and inserting ''5-year extension''.

SEC. 10314. ADJUSTMENT TO LOW-VOLUME HOSPITAL PROVISION.

Section 1886(d)(12) of the Social Security Act (42 U.S.C. 1395ww(d)(12), as amended by section 3125, is amended—

(1) in subparagraph (C)(i), by striking ''1,500 discharges'' and inserting ''1,600 discharges''; and

(2) in subparagraph (D), by striking ''1,500 discharges'' and inserting ''1,600 discharges''.

SEC. 10315. REVISIONS TO HOME HEALTH CARE PROVISIONS.

(a) REBASING.—Section 1895(b)(3)(A)(iii) of the Social Security Act, as added by section 3131, is amended—

(1) in the clause heading, by striking ''2013'' and inserting ''2014'';

(2) in subclause (I), by striking ''2013'' and inserting ''2014''; and

(3) in subclause (II), by striking ''2016'' and inserting ''2017''.

(b) REVISION OF HOME HEALTH STUDY AND REPORT.—Section 3131(d) is amended to read as follows:

''(d) STUDY AND REPORT ON THE DEVELOPMENT OF HOME HEALTH PAYMENT REVISIONS IN ORDER TO ENSURE ACCESS TO CARE AND PAYMENT FOR SEVERITY OF ILLNESS.—

''(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall conduct a study on home health agency costs involved with providing ongoing access to care to low-income Medicare beneficiaries or beneficiaries in medically underserved areas, and in treating beneficiaries with varying levels of severity of illness. In conducting the study, the Secretary may analyze items such as the following:

''(A) Methods to potentially revise the home health prospective payment system under section 1895 of the Social Security Act (42 U.S.C. 1395fff) to account for costs related to patient severity of illness or to improving beneficiary access to care, such as—

''(i) payment adjustments for services that may involve additional or fewer resources;

''(ii) changes to reflect resources involved with providing home health services to low-income Medicare beneficiaries or Medicare beneficiaries residing in medically underserved areas;

''(iii) ways outlier payments might be revised to reflect costs of treating Medicare beneficiaries with high levels of severity of illness; and

''(iv) other issues determined appropriate by the Secretary.

''(B) Operational issues involved with potential implementation of potential revisions to the home health payment system, including impacts for both home health agencies and administrative and systems issues for the Centers for Medicare & Medicaid Services, and any possible payment vulnerabilities associated with implementing potential revisions.

''(C) Whether additional research might be needed.

''(D) Other items determined appropriate by the Secretary.

''(2) CONSIDERATIONS.—In conducting the study under paragraph (1), the Secretary may consider whether patient severity of illness and access to care could be measured by factors, such as—

''(A) population density and relative patient access to care;

''(B) variations in service costs for providing care to individuals who are dually eligible under the Medicare and Medicaid programs;

''(C) the presence of severe or chronic diseases, which might be measured by multiple, discontinuous home health episodes;

''(D) poverty status, such as evidenced by the receipt of Supplemental Security Income under title XVI of the Social Security Act; and

''(E) other factors determined appropriate by the Secretary.

''(3) REPORT.—Not later than March 1, 2014, 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), the Secretary shall consult with appropriate stakeholders, such as groups representing home health agencies and groups representing Medicare beneficiaries.

''(5) MEDICARE DEMONSTRATION PROJECT BASED ON THE RESULTS OF THE STUDY.—

''(A) IN GENERAL.—Subject to subparagraph (D), taking into account the results of the study conducted under paragraph (1), the Secretary may, as determined appropriate, provide for a demonstration project to test whether making payment adjustments for home health services under the Medicare program would substantially improve access to care for patients with high severity levels of illness or for low-income or underserved Medicare beneficiaries.

''(B) WAIVING BUDGET NEUTRALITY.—The Secretary shall not reduce the standard prospective payment amount (or amounts) under section 1895 of the Social Security Act (42 U.S.C. 1395fff) applicable to home health services furnished during a period to offset any increase in payments during such period resulting from the application of the payment adjustments under subparagraph (A).

''(C) NO EFFECT ON SUBSEQUENT PERIODS.—A payment adjustment resulting from the application of subparagraph (A) for a period—

''(i) shall not apply to payments for home health services under title XVIII after such period; and

''(ii) shall not be taken into account in calculating the payment amounts applicable for such services after such period.

''(D) DURATION.—If the Secretary determines it appropriate to conduct the demonstration project under this subsection, the Secretary shall conduct the project for a four year period beginning not later than January 1, 2015.

''(E) FUNDING.—The Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t), in such proportion as the Secretary determines appropriate, of $500,000,000 for the period of fiscal years 2015 through 2018. Such funds shall be made available for the study described in paragraph (1) and the design, implementation and evaluation of the demonstration described in this paragraph. Amounts available under this subparagraph shall be available until expended.

''(F) EVALUATION AND REPORT.—If the Secretary determines it appropriate to conduct the demonstration project under this subsection, the Secretary shall—

''(i) provide for an evaluation of the project; and

''(ii) submit to Congress, by a date specified by the Secretary, a report on the project.

''(G) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply with respect to this subsection.''.

SEC. 10316. MEDICARE DSH.

Section 1886(r)(2)(B) of the Social Security Act, as added by section 3133, is amended—

(1) in clause (i)—

(A) in the matter preceding subclause (I), by striking ''(divided by 100)'';

(B) in subclause (I), by striking ''2012'' and inserting ''2013'';

(C) in subclause (II), by striking the period at the end and inserting a comma; and

(D) by adding at the end the following flush matter:

''minus 1.5 percentage points.''.

(2) in clause (ii)—

(A) in the matter preceding subclause (I), by striking ''(divided by 100)'';

(B) in subclause (I), by striking ''2012'' and inserting ''2013'';

(C) in subclause (II), by striking the period at the end and inserting a comma; and

(D) by adding at the end the following flush matter:

''and, for each of 2018 and 2019, minus 1.5 percentage points.''.

SEC. 10317. REVISIONS TO EXTENSION OF SECTION 508 HOSPITAL PROVISIONS.

Section 3137(a) is amended to read as follows:

''(a) EXTENSION.—

''(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 section 124 of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275), is amended by striking 'September 30, 2009' and inserting 'September 30, 2010'.

''(2) SPECIAL RULE FOR FISCAL YEAR 2010.—

''(A) IN GENERAL.—Subject to subparagraph (B), for purposes of implementation of the amendment made by paragraph (1), including (notwithstanding paragraph (3) of section 117(a) of the Medicare, Medicaid and SCHIP Extension Act of 2007 (Public Law 110–173), as amended by section 124(b) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275)) for purposes of the implementation of paragraph (2) of such section 117(a), during fiscal year 2010, the Secretary of Health and Human Services (in this subsection referred to as the 'Secretary') shall use the hospital wage index that was promulgated by the Secretary in the Federal Register on August 27, 2009 (74 Fed. Reg. 43754), and any subsequent corrections.

''(B) EXCEPTION.—Beginning on April 1, 2010, in determining the wage index applicable to hospitals that qualify for wage index reclassification, the Secretary shall include the average hourly wage data of hospitals whose reclassification was extended pursuant to the amendment made by paragraph (1) only if including such data results in a higher applicable reclassified wage index.

''(3) ADJUSTMENT FOR CERTAIN HOSPITALS IN FISCAL YEAR 2010.—

''(A) IN GENERAL.—In the case of a subsection (d) hospital (as defined in subsection (d)(1)(B) of section 1886 of the Social Security Act (42 U.S.C. 1395ww)) with respect to which—

''(i) a reclassification of its wage index for purposes of such section was extended pursuant to the amendment made by paragraph (1); and

''(ii) the wage index applicable for such hospital for the period beginning on October 1, 2009, and ending on March 31, 2010, was lower than for the period beginning on April 1, 2010, and ending on September 30, 2010, by reason of the application of paragraph (2)(B); the Secretary shall pay such hospital an additional payment that reflects the difference between the wage index for such periods.

''(B) TIMEFRAME FOR PAYMENTS.—The Secretary shall make payments required under subparagraph by not later than December 31, 2010.''.

SEC. 10318. REVISIONS TO TRANSITIONAL EXTRA BENEFITS UNDER MEDICARE ADVANTAGE.

Section 1853(p)(3)(A) of the Social Security Act, as added by section 3201(h), is amended by inserting ''in 2009'' before the period at the end.

SEC. 10319. REVISIONS TO MARKET BASKET ADJUSTMENTS.

(a) INPATIENT ACUTE HOSPITALS.—Section 1886(b)(3)(B)(xii) of the Social Security Act, as added by section 3401(a), is amended—

(1) in subclause (I), by striking ''and'' at the end;

(2) by redesignating subclause (II) as subclause (III);

(3) by inserting after subclause (II) the following new subclause:

''(II) for each of fiscal years 2012 and 2013, by 0.1 percentage point; and''; and

(4) in subclause (III), as redesignated by paragraph (2), by striking ''2012'' and inserting ''2014''.

(b) LONG-TERM CARE HOSPITALS.—Section 1886(m)(4) of the Social Security Act, as added by section 3401(c), is amended—

(1) in subparagraph (A)—

(A) in clause (i)—

(i) by striking ''each of rate years 2010 and 2011'' and inserting ''rate year 2010''; and

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

(B) by redesignating clause (ii) as clause (iv);

(C) by inserting after clause (i) the following new clauses:

''(ii) for rate year 2011, 0.50 percentage point;

''(iii) for each of the rate years beginning in 2012 and 2013, 0.1 percentage point; and''; and

(D) in clause (iv), as redesignated by subparagraph (B), by striking ''2012'' and inserting ''2014''; and

(2) in subparagraph (B), by striking ''(A)(ii)'' and inserting ''(A)(iv)''.

(c) INPATIENT REHABILITATION FACILITIES.—Section 1886(j)(3)(D)(i) of the Social Security Act, as added by section 3401(d), is amended—

(1) in subclause (I), by striking ''and'' at the end;

(2) by redesignating subclause (II) as subclause (III);

(3) by inserting after subclause (II) the following new subclause:

''(II) for each of fiscal years 2012 and 2013, 0.1 percentage point; and''; and

(4) in subclause (III), as redesignated by paragraph (2), by striking ''2012'' and inserting ''2014''.

(d) HOME HEALTH AGENCIES.—Section 1895(b)(3)(B)(vi)(II) of such Act, as added by section 3401(e), is amended by striking ''and 2012'' and inserting '', 2012, and 2013''.

(e) PSYCHIATRIC HOSPITALS.—Section 1886(s)(3)(A) of the Social Security Act, as added by section 3401(f), is amended—

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

(2) by redesignating clause (ii) as clause (iii);

(3) by inserting after clause (ii) the following new clause:

''(ii) for each of the rate years beginning in 2012 and 2013, 0.1 percentage point; and''; and

(4) in clause (iii), as redesignated by paragraph (2), by striking ''2012'' and inserting ''2014''.

(f) HOSPICE CARE.—Section 1814(i)(1)(C) of the Social Security Act (42 U.S.C. 1395f(i)(1)(C)), as amended by section 3401(g), is amended—

(1) in clause (iv)(II), by striking ''0.5'' and inserting ''0.3''; and

(2) in clause (v), in the matter preceding subclause (I), by striking ''0.5'' and inserting ''0.3''.

(g) OUTPATIENT HOSPITALS.—Section 1833(t)(3)(G)(i) of the Social Security Act, as added by section 3401(i), is amended—

(1) in subclause (I), by striking ''and'' at the end;

(2) by redesignating subclause (II) as subclause (III);

(3) by inserting after subclause (II) the following new subclause:

''(II) for each of 2012 and 2013, 0.1 percentage point; and''; and

(4) in subclause (III), as redesignated by paragraph (2), by striking ''2012'' and inserting ''2014''.

SEC. 10320. EXPANSION OF THE SCOPE OF, AND ADDITIONAL IMPROVEMENTS TO, THE INDEPENDENT MEDICARE ADVISORY BOARD.

(a) IN GENERAL.—Section 1899A of the Social Security Act, as added by section 3403, is amended—

(1) in subsection (c)—

(A) in paragraph (1)(B), by adding at the end the following new sentence: ''In any year (beginning with 2014) that the Board is not required to submit a proposal under this section, the Board shall submit to Congress an advisory report on matters related to the Medicare program.'';

(B) in paragraph (2)(A)—

(i) in clause (iv), by inserting ''or the full premium subsidy under section 1860D–14(a)'' before the period at the end of the last sentence; and

(ii) by adding at the end the following new clause:

''(vii) If the Chief Actuary of the Centers for Medicare & Medicaid Services has made a determination described in subsection (e)(3)(B)(i)(II) in the determination year, the proposal shall be designed to help reduce the growth rate described in paragraph (8) while maintaining or enhancing beneficiary access to quality care under this title.'';

(C) in paragraph (2)(B)—

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

(ii) in clause (vi), by striking the period at the end and inserting ''; and''; and

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

''(vii) take into account the data and findings contained in the annual reports under subsection (n) in order to develop proposals that can most effectively promote the delivery of efficient, high quality care to Medicare beneficiaries.'';

(D) in paragraph (3)—

(i) in the heading, by striking ''TRANSMISSION OF BOARD PROPOSAL TO PRESIDENT'' and inserting ''SUBMISSION OF BOARD PROPOSAL TO CONGRESS AND THE PRESIDENT'';

(ii) in subparagraph (A)(i), by striking ''transmit a proposal under this section to the President'' and insert ''submit a proposal under this section to Congress and the President''; and

(iii) in subparagraph (A)(ii)—

(I) in subclause (I), by inserting ''or'' at the end;

(II) in subclause (II), by striking ''; or'' and inserting a period; and

(III) by striking subclause (III);

(E) in paragraph (4)—

(i) by striking ''the Board under paragraph (3)(A)(i) or''; and

(ii) by striking ''immediately'' and inserting ''within 2 days'';

(F) in paragraph (5)—

(i) by striking ''to but'' and inserting ''but''; and

(ii) by inserting ''Congress and'' after ''submit a proposal to''; and

(G) in paragraph (6)(B)(i), by striking ''per unduplicated enrollee'' and inserting ''(calculated as the sum of per capita spending under each of parts A, B, and D)'';

(2) in subsection (d)—

(A) in paragraph (1)(A)—

(i) by inserting ''the Board or'' after ''a proposal is submitted by''; and

(ii) by inserting ''subsection (c)(3)(A)(i) or'' after ''the Senate under''; and

(B) in paragraph (2)(A), by inserting ''the Board or'' after ''a proposal is submitted by'';

(3) in subsection (e)—

(A) in paragraph (1), by inserting ''the Board or'' after ''a proposal submitted by''; and

(B) in paragraph (3)—

(i) by striking ''EXCEPTION.—The Secretary shall not be required to implement the recommendations contained in a proposal submitted in a proposal year by'' and inserting ''EXCEPTIONS.—

''(A) IN GENERAL.—The Secretary shall not implement the recommendations contained in a proposal submitted in a proposal year by the Board or'';

(ii) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively, and indenting appropriately; and

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

''(B) LIMITED ADDITIONAL EXCEPTION.—

''(i) IN GENERAL.—Subject to clause (ii), the Secretary shall not implement the recommendations contained in a proposal submitted by the Board or the President to Congress pursuant to this section in a proposal year (beginning with proposal year 2019) if—

''(I) the Board was required to submit a proposal to Congress under this section in the year preceding the proposal year; and

''(II) the Chief Actuary of the Centers for Medicare & Medicaid Services makes a determination in the determination year that the growth rate described in subsection (c)(8) exceeds the growth rate described in subsection (c)(6)(A)(i).

''(ii) LIMITED ADDITIONAL EXCEPTION MAY NOT BE APPLIED IN TWO CONSECUTIVE YEARS.—This subparagraph shall not apply if the recommendations contained in a proposal submitted by the Board or the President to Congress pursuant to this section in the year preceding the proposal year were not required to be implemented by reason of this subparagraph.

''(iii) NO AFFECT ON REQUIREMENT TO SUBMIT PROPOSALS OR FOR CONGRESSIONAL CONSIDERATION OF PROPOSALS.—Clause (i) and (ii) shall not affect—

''(I) the requirement of the Board or the President to submit a proposal to Congress in a proposal year in accordance with the provisions of this section; or

''(II) Congressional consideration of a legislative proposal (described in subsection (c)(3)(B)(iv)) contained such a proposal in accordance with subsection (d).'';

(4) in subsection (f)(3)(B)—

(A) by striking ''or advisory reports to Congress'' and inserting '', advisory reports, or advisory recommendations''; and

(B) by inserting ''or produce the public report under subsection (n)'' after ''this section''; and

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

''(n) ANNUAL PUBLIC REPORT.—

''(1) IN GENERAL.—Not later than July 1, 2014, and annually thereafter, the Board shall produce a public report containing standardized information on system-wide health care costs, patient access to care, utilization, and quality-of-care that allows for comparison by region, types of services, types of providers, and both private payers and the program under this title.

''(2) REQUIREMENTS.—Each report produced pursuant to paragraph (1) shall include information with respect to the following areas:

''(A) The quality and costs of care for the population at the most local level determined practical by the Board (with quality and costs compared to national benchmarks and reflecting rates of change, taking into account quality measures described in section 1890(b)(7)(B)).

''(B) Beneficiary and consumer access to care, patient and caregiver experience of care, and the cost-sharing or out-of-pocket burden on patients.

''(C) Epidemiological shifts and demographic changes.

''(D) The proliferation, effectiveness, and utilization of health care technologies, including variation in provider practice patterns and costs.

''(E) Any other areas that the Board determines affect overall spending and quality of care in the private sector.

''(o) ADVISORY RECOMMENDATIONS FOR NON-FEDERAL HEALTH CARE PROGRAMS.—

''(1) IN GENERAL.—Not later than January 15, 2015, and at least once every two years thereafter, the Board shall submit to Congress and the President recommendations to slow the growth in national health expenditures (excluding expenditures under this title and in other Federal health care programs) while preserving or enhancing quality of care, such as recommendations—

''(A) that the Secretary or other Federal agencies can implement administratively;

''(B) that may require legislation to be enacted by Congress in order to be implemented;

''(C) that may require legislation to be enacted by State or local governments in order to be implemented;

''(D) that private sector entities can voluntarily implement; and

''(E) with respect to other areas determined appropriate by the Board.

''(2) COORDINATION.—In making recommendations under paragraph (1), the Board shall coordinate such recommendations with recommendations contained in proposals and advisory reports produced by the Board under subsection (c).

''(3) AVAILABLE TO PUBLIC.—The Board shall make recommendations submitted to Congress and the President under this subsection available to the public.''.

(b) NAME CHANGE.—Any reference in the provisions of, or amendments made by, section 3403 to the ''Independent Medicare Advisory Board'' shall be deemed to be a reference to the ''Independent Payment Advisory Board''.

(c) RULE OF CONSTRUCTION.—Nothing in the amendments made by this section shall preclude the Independent Medicare Advisory Board, as established under section 1899A of the Social Security Act (as added by section 3403), from solely using data from public or private sources to carry out the amendments made by subsection (a)(4).

SEC. 10321. REVISION TO COMMUNITY HEALTH TEAMS.

Section 3502(c)(2)(A) is amended by inserting ''or other primary care providers'' after ''physicians''.

SEC. 10322. QUALITY REPORTING FOR PSYCHIATRIC HOSPITALS.

(a) IN GENERAL.—Section 1886(s) of the Social Security Act, as added by section 3401(f), is amended by adding at the end the following new paragraph:

''(4) 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 psychiatric hospital or psychiatric unit 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 (2), 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 apply only with respect to the rate year involved and the Secretary shall not take into account such reduction in computing the payment amount under the system described in paragraph (1) for a subsequent rate year.

''(C) SUBMISSION OF QUALITY DATA.—For rate year 2014 and each subsequent rate year, each psychiatric hospital and psychiatric unit 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 rate 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 psychiatric hospital and a psychiatric unit has the opportunity to review the data that is to be made public with respect to the hospital or unit prior to such data being made public. The Secretary shall report quality measures that relate to services furnished in inpatient settings in psychiatric hospitals and psychiatric units on the Internet website of the Centers for Medicare & Medicaid Services.''.

(b) CONFORMING AMENDMENT.—Section 1890(b)(7)(B)(i)(I) of the Social Security Act, as added by section 3014, is amended by inserting ''1886(s)(4)(D),'' after ''1886(o)(2),''.

SEC. 10323. MEDICARE COVERAGE FOR INDIVIDUALS EXPOSED TO ENVIRONMENTAL HEALTH HAZARDS.

(a) IN GENERAL.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by inserting after section 1881 the following new section:

''SEC. 1881A. MEDICARE COVERAGE FOR INDIVIDUALS EXPOSED TO ENVIRONMENTAL HEALTH HAZARDS.

''(a) DEEMING OF INDIVIDUALS AS ELIGIBLE FOR MEDICARE BENEFITS.—

''(1) IN GENERAL.—For purposes of eligibility for benefits under this title, an individual determined under subsection (c) to be an environmental exposure affected individual described in subsection (e)(2) shall be deemed to meet the conditions specified in section 226(a).

''(2) DISCRETIONARY DEEMING.—For purposes of eligibility for benefits under this title, the Secretary may deem an individual determined under subsection (c) to be an environmental exposure affected individual described in subsection (e)(3) to meet the conditions specified in section 226(a).

''(3) EFFECTIVE DATE OF COVERAGE.—An Individual who is deemed eligible for benefits under this title under paragraph (1) or (2) shall be—

''(A) entitled to benefits under the program under Part A as of the date of such deeming; and

''(B) eligible to enroll in the program under Part B beginning with the month in which such deeming occurs.

''(b) PILOT PROGRAM FOR CARE OF CERTAIN INDIVIDUALS RESIDING IN EMERGENCY DECLARATION AREAS.—

''(1) PROGRAM; PURPOSE.—

''(A) PRIMARY PILOT PROGRAM.—The Secretary shall establish a pilot program in accordance with this subsection to provide innovative approaches to furnishing comprehensive, coordinated, and cost-effective care under this title to individuals described in paragraph (2)(A).

''(B) OPTIONAL PILOT PROGRAMS.—The Secretary may establish a separate pilot program, in accordance with this subsection, with respect to each geographic area subject to an emergency declaration (other than the declaration of June 17, 2009), in order to furnish such comprehensive, coordinated and cost-effective care to individuals described in subparagraph (2)(B) who reside in each such area.

''(2) INDIVIDUAL DESCRIBED.—For purposes of paragraph (1), an individual described in this paragraph is an individual who enrolls in part B, submits to the Secretary an application to participate in the applicable pilot program under this subsection, and—

''(A) is an environmental exposure affected individual described in subsection (e)(2) who resides in or around the geographic area subject to an emergency declaration made as of June 17, 2009; or

''(B) is an environmental exposure affected individual described in subsection (e)(3) who—

''(i) is deemed under subsection (a)(2); and

''(ii) meets such other criteria or conditions for participation in a pilot program under paragraph (1)(B) as the Secretary specifies.

''(3) FLEXIBLE BENEFITS AND SERVICES.—A pilot program under this subsection may

provide for the furnishing of benefits, items, or services not otherwise covered or authorized under this title, if the Secretary determines that furnishing such benefits, items, or services will further the purposes of such pilot program (as described in paragraph (1)).

''(4) INNOVATIVE REIMBURSEMENT METHODOLOGIES.—For purposes of the pilot program under this subsection, the Secretary—

''(A) shall develop and implement appropriate methodologies to reimburse providers for furnishing benefits, items, or services for which payment is not otherwise covered or authorized under this title, if such benefits, items, or services are furnished pursuant to paragraph (3); and

''(B) may develop and implement innovative approaches to reimbursing providers for any benefits, items, or services furnished under this subsection.

''(5) LIMITATION.—Consistent with section 1862(b), no payment shall be made under the pilot program under this subsection with respect to benefits, items, or services furnished to an environmental exposure affected individual (as defined in subsection (e)) to the extent that such individual is eligible to receive such benefits, items, or services through any other public or private benefits plan or legal agreement.

''(6) WAIVER AUTHORITY.—The Secretary may waive such provisions of this title and title XI as are necessary to carry out pilot programs under this subsection.

''(7) FUNDING.—For purposes of carrying out pilot programs under this subsection, the Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1841, in such proportion as the Secretary determines appropriate, of such sums as the Secretary determines necessary, to the Centers for Medicare & Medicaid Services Program Management Account.

''(8) WAIVER OF BUDGET NEUTRALITY.—The Secretary shall not require that pilot programs under this subsection be budget neutral with respect to expenditures under this title.

''(c) DETERMINATIONS.—

''(1) BY THE COMMISSIONER OF SOCIAL SECURITY.—For purposes of this section, the Commissioner of Social Security, in consultation with the Secretary, and using the cost allocation method prescribed in section 201(g), shall determine whether individuals are environmental exposure affected individuals.

''(2) BY THE SECRETARY.—The Secretary shall determine eligibility for pilot programs under subsection (b).

''(d) EMERGENCY DECLARATION DEFINED.—For purposes of this section, the term 'emergency declaration' means a declaration of a public health emergency under section 104(a) of the Comprehensive Environmental Response, Compensation, and Liability Act of 1980.

''(e) ENVIRONMENTAL EXPOSURE AFFECTED INDIVIDUAL DEFINED.—

''(1) IN GENERAL.—For purposes of this section, the term 'environmental exposure affected individual' means—

''(A) an individual described in paragraph (2); and

''(B) an individual described in paragraph (3).

''(2) INDIVIDUAL DESCRIBED.—

''(A) IN GENERAL.—An individual described in this paragraph is any individual who—

''(i) is diagnosed with 1 or more conditions described in subparagraph (B);

''(ii) as demonstrated in such manner as the Secretary determines appropriate, has been present for an aggregate total of 6 months in the geographic area subject to an emergency declaration specified in subsection (b)(2)(A), during a period ending—

''(I) not less than 10 years prior to such diagnosis; and

''(II) prior to the implementation of all the remedial and removal actions specified in the Record of Decision for Operating Unit 4 and the Record of Decision for Operating Unit 7;

''(iii) files an application for benefits under this title (or has an application filed on behalf of the individual), including pursuant to this section; and

''(iv) is determined under this section to meet the criteria in this subparagraph.

''(B) CONDITIONS DESCRIBED.—For purposes of subparagraph (A), the following conditions are described in this subparagraph:

''(i) Asbestosis, pleural thickening, or pleural plaques as established by—

''(I) interpretation by a 'B Reader' qualified physician of a plain chest x-ray or interpretation of a computed tomographic radiograph of the chest by a qualified physician, as determined by the Secretary; or

''(II) such other diagnostic standards as the Secretary specifies,

except that this clause shall not apply to pleural thickening or pleural plaques unless there are symptoms or conditions requiring medical treatment as a result of these diagnoses.

''(ii) Mesothelioma, or malignancies of the lung, colon, rectum, larynx, stomach, esophagus, pharynx, or ovary, as established by—

''(I) pathologic examination of biopsy tissue;

''(II) cytology from bronchioalveolar lavage; or

''(III) such other diagnostic standards as the Secretary specifies.

''(iii) Any other diagnosis which the Secretary, in consultation with the Commissioner of Social Security, determines is an asbestos-related medical condition, as established by such diagnostic standards as the Secretary specifies.

''(3) OTHER INDIVIDUAL DESCRIBED.—An individual described in this paragraph is any individual who—

''(A) is not an individual described in paragraph (2);

''(B) is diagnosed with a medical condition caused by the exposure of the individual to a public health hazard to which an emergency declaration applies, based on such medical conditions, diagnostic standards, and other criteria as the Secretary specifies;

''(C) as demonstrated in such manner as the Secretary determines appropriate, has been present for an aggregate total of 6 months in the geographic area subject to the emergency declaration involved, during a period determined appropriate by the Secretary;

''(D) files an application for benefits under this title (or has an application filed on behalf of the individual), including pursuant to this section; and

''(E) is determined under this section to meet the criteria in this paragraph.''.

(b) PROGRAM FOR EARLY DETECTION OF CERTAIN MEDICAL CONDITIONS RELATED TO ENVIRONMENTAL HEALTH HAZARDS.—Title XX of the Social Security Act (42 U.S.C. 1397 et seq.), as amended by section 5507, is amended by adding at the end the following:

''SEC. 2009. PROGRAM FOR EARLY DETECTION OF CERTAIN MEDICAL CONDITIONS RELATED TO ENVIRONMENTAL HEALTH HAZARDS.

''(a) PROGRAM ESTABLISHMENT.—The Secretary shall establish a program in accordance with this section to make competitive grants to eligible entities specified in subsection (b) for the purpose of—

''(1) screening at-risk individuals (as defined in subsection (c)(1)) for environmental health conditions (as defined in subsection (c)(3)); and

''(2) developing and disseminating public information and education concerning—

''(A) the availability of screening under the program under this section;

''(B) the detection, prevention, and treatment of environmental health conditions; and

''(C) the availability of Medicare benefits for certain individuals diagnosed with environmental health conditions under section 1881A.

''(b) ELIGIBLE ENTITIES.—

''(1) IN GENERAL.—For purposes of this section, an eligible entity is an entity described in paragraph (2) which submits an application to the Secretary in such form and manner, and containing such information and assurances, as the Secretary determines appropriate.

''(2) TYPES OF ELIGIBLE ENTITIES.—The entities described in this paragraph are the following:

''(A) A hospital or community health center.

''(B) A Federally qualified health center.

''(C) A facility of the Indian Health Service.

''(D) A National Cancer Institute-designated cancer center.

''(E) An agency of any State or local government.

''(F) A nonprofit organization.

''(G) Any other entity the Secretary determines appropriate.

''(c) DEFINITIONS.—In this section:

''(1) AT-RISK INDIVIDUAL.—The term 'at-risk individual' means an individual who—

''(A)(i) as demonstrated in such manner as the Secretary determines appropriate, has been present for an aggregate total of 6 months in the geographic area subject to an emergency declaration specified under paragraph (2), during a period ending—

''(I) not less than 10 years prior to the date of such individual's application under subparagraph (B); and

''(II) prior to the implementation of all the remedial and removal actions specified in the Record of Decision for Operating Unit 4 and the Record of Decision for Operating Unit 7; or

''(ii) meets such other criteria as the Secretary determines appropriate considering the type of environmental health condition at issue; and

''(B) has submitted an application (or has an application submitted on the individual's behalf), to an eligible entity receiving a grant under this section, for screening under the program under this section.

''(2) EMERGENCY DECLARATION.—The term 'emergency declaration' means a declaration of a public health emergency under section 104(a) of the Comprehensive Environmental Response, Compensation, and Liability Act of 1980.

''(3) ENVIRONMENTAL HEALTH CONDITION.—The term 'environmental health condition' means—

''(A) asbestosis, pleural thickening, or pleural plaques, as established by—

''(i) interpretation by a 'B Reader' qualified physician of a plain chest x-ray or interpretation of a computed tomographic radiograph of the chest by a qualified physician, as determined by the Secretary; or

''(ii) such other diagnostic standards as the Secretary specifies;

''(B) mesothelioma, or malignancies of the lung, colon, rectum, larynx, stomach, esophagus, pharynx, or ovary, as established by—

''(i) pathologic examination of biopsy tissue;

''(ii) cytology from bronchioalveolar lavage; or

''(iii) such other diagnostic standards as the Secretary specifies; and

''(C) any other medical condition which the Secretary determines is caused by exposure to a hazardous substance or pollutant or contaminant at a Superfund site to which an emergency declaration applies, based on such criteria and as established by such diagnostic standards as the Secretary specifies.

''(4) HAZARDOUS SUBSTANCE; POLLUTANT; CONTAMINANT.—The terms 'hazardous substance', 'pollutant', and 'contaminant' have the meanings given those terms in section 101 of the Comprehensive Environmental Response, Compensation, and Liability Act of 1980 (42 U.S.C. 9601).

''(5) SUPERFUND SITE.—The term 'Superfund site' means a site included on the National Priorities List developed by the President in accordance with section 105(a)(8)(B) of the Comprehensive Environmental Response, Compensation, and Liability Act of 1980 (42 U.S.C. 9605(a)(8)(B)).

''(d) HEALTH COVERAGE UNAFFECTED.—Nothing in this section shall be construed to affect any coverage obligation of a governmental or private health plan or program relating to an at-risk individual.

''(e) FUNDING.—

''(1) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary, to carry out the program under this section—

''(A) $23,000,000 for the period of fiscal years 2010 through 2014; and

''(B) $20,000,000 for each 5-fiscal year period thereafter.

''(2) AVAILABILITY.—Funds appropriated under paragraph (1) shall remain available until expended.

''(f) NONAPPLICATION.—

''(1) IN GENERAL.—Except as provided in paragraph (2), the preceding sections of this title shall not apply to grants awarded under this section.

''(2) LIMITATIONS ON USE OF GRANTS.—Section 2005(a) 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, except that paragraph (4) of such section shall not be construed to prohibit grantees from conducting screening for environmental health conditions as authorized under this section.''.

SEC. 10324. PROTECTIONS FOR FRONTIER STATES.

(a) FLOOR ON AREA WAGE INDEX FOR HOSPITALS IN FRONTIER STATES.—

(1) IN GENERAL.—Section 1886(d)(3)(E) of the Social Security Act (42 U.S.C. 1395ww(d)(3)(E)) is amended—

(A) in clause (i), by striking ''clause (ii)'' and inserting ''clause (ii) or (iii)''; and

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

''(iii) FLOOR ON AREA WAGE INDEX FOR HOSPITALS IN FRONTIER STATES.—

''(I) IN GENERAL.—Subject to subclause (IV), for discharges occurring on or after October 1, 2010, the area wage index applicable under this subparagraph to any hospital which is located in a frontier State (as defined in subclause (II)) may not be less than 1.00.

''(II) FRONTIER STATE DEFINED.—In this clause, the term 'frontier State' means a State in which at least 50 percent of the counties in the State are frontier counties.

''(III) FRONTIER COUNTY DEFINED.—In this clause, the term 'frontier county' means a county in which the population per square mile is less than 6.

''(IV) LIMITATION.—This clause shall not apply to any hospital located in a State that receives a non-labor related share adjustment under paragraph (5)(H).''.

(2) WAIVING BUDGET NEUTRALITY.—Section 1886(d)(3)(E) of the Social Security Act (42 U.S.C. 1395ww(d)(3)(E)), as amended by subsection (a), is amended in the third sentence by inserting ''and the amendments made by section 10324(a)(1) of the Patient Protection and Affordable Care Act'' after ''2003''.

(b) FLOOR ON AREA WAGE ADJUSTMENT FACTOR FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES IN FRONTIER STATES.—Section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)), as amended by section 3138, is amended—

(1) in paragraph (2)(D), by striking ''the Secretary'' and inserting ''subject to paragraph (19), the Secretary''; and

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

''(19) FLOOR ON AREA WAGE ADJUSTMENT FACTOR FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES IN FRONTIER STATES.—

''(A) IN GENERAL.—Subject to subparagraph (B), with respect to covered OPD services furnished on or after January 1, 2011, the area wage adjustment factor applicable under the payment system established under this subsection to any hospital outpatient department which is located in a frontier State (as defined in section 1886(d)(3)(E)(iii)(II)) may not be less than 1.00. The preceding sentence shall not be applied in a budget neutral manner.

''(B) LIMITATION.—This paragraph shall not apply to any hospital outpatient department located in a State that receives a non-labor related share adjustment under section 1886(d)(5)(H).''.

(c) FLOOR FOR PRACTICE EXPENSE INDEX FOR PHYSICIANS' SERVICES FURNISHED IN FRONTIER STATES.—Section 1848(e)(1) of the Social Security Act (42 U.S.C. 1395w–4(e)(1)), as amended by section 3102, is amended—

(1) in subparagraph (A), by striking ''and (H)'' and inserting ''(H), and (I)''; and

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

''(I) FLOOR FOR PRACTICE EXPENSE INDEX FOR SERVICES FURNISHED IN FRONTIER STATES.—

''(i) IN GENERAL.—Subject to clause (ii), for purposes of payment for services furnished in a frontier State (as defined in section 1886(d)(3)(E)(iii)(II)) on or after January 1, 2011, after calculating the practice expense index in subparagraph (A)(i), the Secretary shall increase any such index to 1.00 if such index would otherwise be less that 1.00. The preceding sentence shall not be applied in a budget neutral manner.

''(ii) LIMITATION.—This subparagraph shall not apply to services furnished in a State that receives a non-labor related share adjustment under section 1886(d)(5)(H).''.

SEC. 10325. REVISION TO SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM.

(a) TEMPORARY DELAY OF RUG-IV.—Notwithstanding any other provision of law, the Secretary of Health and Human Services shall not, prior to October 1, 2011, implement Version 4 of the Resource Utilization Groups (in this subsection refereed to as ''RUG-IV'') published in the Federal Register on August 11, 2009, entitled ''Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2010; Minimum Data Set, Version 3.0 for Skilled Nursing Facilities and Medicaid Nursing Facilities'' (74 Fed. Reg. 40288). Beginning on October 1, 2010, the Secretary of Health and Human Services shall implement the change specific to therapy furnished on a concurrent basis that is a component of RUG-IV and changes to the lookback period to ensure that only those services furnished after admission to a skilled nursing facility are used as factors in determining a case mix classification under the skilled nursing facility prospective payment system under section 1888(e) of the Social Security Act (42 U.S.C. 1395yy(e)).

(b) CONSTRUCTION.—Nothing in this section shall be interpreted as delaying the implementation of Version 3.0 of the Minimum Data Sets (MDS 3.0) beyond the planned implementation date of October 1, 2010.

SEC. 10326. PILOT TESTING PAY-FOR-PERFORMANCE PROGRAMS FOR CERTAIN MEDICARE PROVIDERS.

(a) IN GENERAL.—Not later than January 1, 2016, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall, for each provider described in subsection (b), conduct a separate pilot program under title XVIII of the Social Security Act to test the implementation of a value-based purchasing program for payments under such title for the provider.

(b) PROVIDERS DESCRIBED.—The providers described in this paragraph are the following:

(1) Psychiatric hospitals (as described in clause (i) of section 1886(d)(1)(B) of such Act (42 U.S.C. 1395ww(d)(1)(B))) and psychiatric units (as described in the matter following clause (v) of such section).

(2) Long-term care hospitals (as described in clause (iv) of such section).

(3) Rehabilitation hospitals (as described in clause (ii) of such section).

(4) PPS-exempt cancer hospitals (as described in clause (v) of such section).

(5) Hospice programs (as defined in section 1861(dd)(2) of such Act (42 U.S.C. 1395x(dd)(2))).

(c) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act as may be necessary solely for purposes of carrying out the pilot programs under this section.

(d) NO ADDITIONAL PROGRAM EXPENDITURES.—Payments under this section under the separate pilot program for value based purchasing (as described in subsection (a)) for each provider type described in paragraphs (1) through (5) of subsection (b) for applicable items and services under title XVIII of the Social Security Act for a year shall be established in a manner that does not result in spending more under each such value based purchasing program for such year than would otherwise be expended for such provider type for such year if the pilot program were not implemented, as estimated by the Secretary.

(e) EXPANSION OF PILOT PROGRAM.—The Secretary may, at any point after January 1, 2018, expand the duration and scope of a pilot program conducted under this subsection, to the extent determined appropriate by the Secretary, if—

(1) the Secretary determines that such expansion is expected to—

(A) reduce spending under title XVIII of the Social Security Act without reducing the quality of care; or

(B) improve the quality of care and reduce spending;

(2) the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that such expansion would reduce program spending under such title XVIII; and

(3) the Secretary determines that such expansion would not deny or limit the coverage or provision of benefits under such title XIII for Medicare beneficiaries.

SEC. 10327. IMPROVEMENTS TO THE PHYSICIAN QUALITY REPORTING SYSTEM.

(a) IN GENERAL.—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) ADDITIONAL INCENTIVE PAYMENT.—

''(A) IN GENERAL.—For 2011 through 2014, if an eligible professional meets the requirements described in subparagraph (B), the applicable quality percent for such year, as described in clauses (iii) and (iv) of paragraph (1)(B), shall be increased by 0.5 percentage points.

''(B) REQUIREMENTS DESCRIBED.—In order to qualify for the additional incentive payment described in subparagraph (A), an eligible professional shall meet the following requirements:

''(i) The eligible professional shall—

''(I) satisfactorily submit data on quality measures for purposes of paragraph (1) for a year; and

''(II) have such data submitted on their behalf through a Maintenance of Certification Program (as defined in subparagraph (C)(i)) that meets—

''(aa) the criteria for a registry (as described in subsection (k)(4)); or

''(bb) an alternative form and manner determined appropriate by the Secretary.

''(ii) The eligible professional, more frequently than is required to qualify for or maintain board certification status—

''(I) participates in such a Maintenance of Certification program for a year; and

''(II) successfully completes a qualified Maintenance of Certification Program practice assessment (as defined in subparagraph (C)(ii)) for such year.

''(iii) A Maintenance of Certification program submits to the Secretary, on behalf of the eligible professional, information—

''(I) in a form and manner specified by the Secretary, that the eligible professional has successfully met the requirements of clause (ii) (which may be in the form of a structural measure);

''(II) if requested by the Secretary, on the survey of patient experience with care (as described in subparagraph (C)(ii)(II)); and

''(III) as the Secretary may require, on the methods, measures, and data used under the Maintenance of Certification Program and the qualified Maintenance of Certification Program practice assessment.

''(C) DEFINITIONS.—For purposes of this paragraph:

''(i) The term 'Maintenance of Certification Program' means a continuous assessment program, such as qualified American Board of Medical Specialties Maintenance of Certification program or an equivalent program (as determined by the Secretary), that advances quality and the lifelong learning and self-assessment of board certified specialty physicians by focusing on the competencies of patient care, medical knowledge, practice-based learning, interpersonal and communication skills and professionalism. Such a program shall include the following:

''(I) The program requires the physician to maintain a valid, unrestricted medical license in the United States.

''(II) The program requires a physician to participate in educational and self-assessment programs that require an assessment of what was learned.

''(III) The program requires a physician to demonstrate, through a formalized, secure examination, that the physician has the fundamental diagnostic skills, medical knowledge, and clinical judgment to provide quality care in their respective specialty.

''(IV) The program requires successful completion of a qualified Maintenance of Certification Program practice assessment as described in clause (ii).

''(ii) The term 'qualified Maintenance of Certification Program practice assessment' means an assessment of a physician's practice that—

''(I) includes an initial assessment of an eligible professional's practice that is designed to demonstrate the physician's use of evidence-based medicine;

''(II) includes a survey of patient experience with care; and

''(III) requires a physician to implement a quality improvement intervention to address a practice weakness identified in the initial assessment under subclause (I) and then to remeasure to assess performance improvement after such intervention.''.

(b) AUTHORITY.—Section 3002(c) of this Act is amended by adding at the end the following new paragraph:

''(3) AUTHORITY.—For years after 2014, if the Secretary of Health and Human Services determines it to be appropriate, the Secretary may incorporate participation in a Maintenance of Certification Program and successful completion of a qualified Maintenance of Certification Program practice assessment into the composite of measures of quality of care furnished pursuant to the physician fee schedule payment modifier, as described in section 1848(p)(2) of the Social Security Act (42 U.S.C. 1395w–4(p)(2)).''.

(c) ELIMINATION OF MA REGIONAL PLAN STABILIZATION FUND.—

(1) IN GENERAL.—Section 1858 of the Social Security Act (42 U.S.C. 1395w–27a) is amended by striking subsection (e).

(2) TRANSITION.—Any amount contained in the MA Regional Plan Stabilization Fund as of the date of the enactment of this Act shall be transferred to the Federal Supplementary Medical Insurance Trust Fund.

SEC. 10328. IMPROVEMENT IN PART D MEDICATION THERAPY MANAGEMENT (MTM) PROGRAMS.

(a) IN GENERAL.—Section 1860D–4(c)(2) of the Social Security Act (42 U.S.C. 1395w–104(c)(2)) is amended—

(1) by redesignating subparagraphs (C), (D), and (E) as subparagraphs (E), (F), and (G), respectively; and

(2) by inserting after subparagraph (B) the following new subparagraphs:

''(C) REQUIRED INTERVENTIONS.—For plan years beginning on or after the date that is 2 years after the date of the enactment of the Patient Protection and Affordable Care Act, prescription drug plan sponsors shall offer medication therapy management services to targeted beneficiaries described in subparagraph (A)(ii) that include, at a minimum, the following to increase adherence to prescription medications or other goals deemed necessary by the Secretary:

''(i) An annual comprehensive medication review furnished person-to-person or using telehealth technologies (as defined by the Secretary) by a licensed pharmacist or other qualified provider. The comprehensive medication review—

''(I) shall include a review of the individual's medications and may result in the creation of a recommended medication action plan or other actions in consultation with the individual and with input from the prescriber to the extent necessary and practicable; and

''(II) shall include providing the individual with a written or printed summary of the results of the review.

The Secretary, in consultation with relevant stakeholders, shall develop a standardized format for the action plan under subclause (I) and the summary under subclause (II).

''(ii) Follow-up interventions as warranted based on the findings of the annual medication review or the targeted medication enrollment and which may be provided person-to-person or using telehealth technologies (as defined by the Secretary).

''(D) ASSESSMENT.—The prescription drug plan sponsor shall have in place a process to assess, at least on a quarterly basis, the medication use of individuals who are at risk but not enrolled in the medication therapy management program, including individuals who have experienced a transition in care, if the prescription drug plan sponsor has access to that information.

''(E) AUTOMATIC ENROLLMENT WITH ABILITY TO OPT-OUT.—The prescription drug plan sponsor shall have in place a process to—

''(i) subject to clause (ii), automatically enroll targeted beneficiaries described in subparagraph (A)(ii), including beneficiaries identified under subparagraph (D), in the medication therapy management program required under this subsection; and

''(ii) permit such beneficiaries to opt-out of enrollment in such program.''.

(b) RULE OF CONSTRUCTION.—Nothing in this section shall limit the authority of the Secretary of Health and Human Services to modify or broaden requirements for a medication therapy management program under part D of title XVIII of the Social Security Act or to study new models for medication therapy management through the Center for Medicare and Medicaid Innovation under section 1115A of such Act, as added by section 3021.

SEC. 10329. DEVELOPING METHODOLOGY TO ASSESS HEALTH PLAN VALUE.

(a) DEVELOPMENT.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary''), in consultation with relevant stakeholders including health insurance issuers, health care consumers, employers, health care providers, and other entities determined appropriate by the Secretary, shall develop a methodology to measure health plan value. Such methodology shall take into consideration, where applicable—

(1) the overall cost to enrollees under the plan;

(2) the quality of the care provided for under the plan;

(3) the efficiency of the plan in providing care;

(4) the relative risk of the plan's enrollees as compared to other plans;

(5) the actuarial value or other comparative measure of the benefits covered under the plan; and

(6) other factors determined relevant by the Secretary.

(b) REPORT.—Not later than 18 months after the date of enactment of this Act, the Secretary shall submit to Congress a report concerning the methodology developed under subsection (a).

SEC. 10330. MODERNIZING COMPUTER AND DATA SYSTEMS OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES TO SUPPORT IMPROVEMENTS IN CARE DELIVERY.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall develop a plan (and detailed budget for the resources needed to implement such plan) to modernize the computer and data systems of the Centers for Medicare & Medicaid Services (in this section referred to as ''CMS'').

(b) CONSIDERATIONS.—In developing the plan, the Secretary shall consider how such modernized computer system could—

(1) in accordance with the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996, make available data in a reliable and timely manner to providers of services and suppliers to support their efforts to better manage and coordinate care furnished to beneficiaries of CMS programs; and

(2) support consistent evaluations of payment and delivery system reforms under CMS programs.

(c) POSTING OF PLAN.—By not later than 9 months after the date of the enactment of this Act, the Secretary shall post on the website of the Centers for Medicare & Medicaid Services the plan described in subsection (a).

SEC. 10331. PUBLIC REPORTING OF PERFORMANCE INFORMATION.

(a) IN GENERAL.—

(1) DEVELOPMENT.—Not later than January 1, 2011, the Secretary shall develop a Physician Compare Internet website with information on physicians enrolled in the Medicare program under section 1866(j) of the Social Security Act (42 U.S.C. 1395cc(j)) and other eligible professionals who participate in the Physician Quality Reporting Initiative under section 1848 of such Act (42 U.S.C. 1395w–4).

(2) PLAN.—Not later than January 1, 2013, and with respect to reporting periods that begin no earlier than January 1, 2012, the Secretary shall also implement a plan for making publicly available through Physician Compare, consistent with subsection (c), information on physician performance that provides comparable information for the public on quality and patient experience measures with respect to physicians enrolled in the Medicare program under such section 1866(j). To the extent scientifically sound measures that are developed consistent with the requirements of this section are available, such information, to the extent practicable, shall include—

(A) measures collected under the Physician Quality Reporting Initiative;

(B) an assessment of patient health outcomes and the functional status of patients;

(C) an assessment of the continuity and coordination of care and care transitions, including episodes of care and risk-adjusted resource use;

(D) an assessment of efficiency;

(E) an assessment of patient experience and patient, caregiver, and family engagement;

(F) an assessment of the safety, effectiveness, and timeliness of care; and

(G) other information as determined appropriate by the Secretary.

(b) OTHER REQUIRED CONSIDERATIONS.—In developing and implementing the plan described in subsection (a)(2), the Secretary shall, to the extent practicable, include—

(1) processes to assure that data made public, either by the Centers for Medicare & Medicaid Services or by other entities, is statistically valid and reliable, including risk adjustment mechanisms used by the Secretary;

(2) processes by which a physician or other eligible professional whose performance on measures is being publicly reported has a reasonable opportunity, as determined by the Secretary, to review his or her individual results before they are made public;

(3) processes by the Secretary to assure that the implementation of the plan and the data made available on Physician Compare provide a robust and accurate portrayal of a physician's performance;

(4) data that reflects the care provided to all patients seen by physicians, under both the Medicare program and, to the extent practicable, other payers, to the extent such information would provide a more accurate portrayal of physician performance;

(5) processes to ensure appropriate attribution of care when multiple physicians and other providers are involved in the care of a patient;

(6) processes to ensure timely statistical performance feedback is provided to physicians concerning the data reported under any program subject to public reporting under this section; and

(7) implementation of computer and data systems of the Centers for Medicare & Medicaid Services that support valid, reliable, and accurate public reporting activities authorized under this section.

(c) ENSURING PATIENT PRIVACY.—The Secretary shall ensure that information on physician performance and patient experience is not disclosed under this section in a manner that violates sections 552 or 552a of title 5, United States Code, with regard to the privacy of individually identifiable health information.

(d) FEEDBACK FROM MULTI-STAKEHOLDER GROUPS.—The Secretary shall take into consideration input provided by multi-stakeholder groups, consistent with sections 1890(b)(7) and 1890A of the Social Security Act, as added by section 3014 of this Act, in selecting quality measures for use under this section.

(e) CONSIDERATION OF TRANSITION TO VALUE-BASED PURCHASING.—In developing the plan under this subsection (a)(2), the Secretary shall, as the Secretary determines appropriate, consider the plan to transition to a value-based purchasing program for physicians and other practitioners developed under section 131 of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275).

(f) REPORT TO CONGRESS.—Not later than January 1, 2015, the Secretary shall submit to Congress a report on the Physician Compare Internet website developed under subsection (a)(1). Such report shall include information on the efforts of and plans made by the Secretary to collect and publish data on physician quality and efficiency and on patient experience of care in support of value-based purchasing and consumer choice, together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

(g) EXPANSION.—At any time before the date on which the report is submitted under subsection (f), the Secretary may expand (including expansion to other providers of services and suppliers under title XVIII of the Social Security Act) the information made available on such website.

(h) FINANCIAL INCENTIVES TO ENCOURAGE CONSUMERS TO CHOOSE HIGH QUALITY PROVIDERS.—The Secretary may establish a demonstration program, not later than January 1, 2019, to provide financial incentives to Medicare beneficiaries who are furnished services by high quality physicians, as determined by the Secretary based on factors in subparagraphs (A) through (G) of subsection (a)(2). In no case may Medicare beneficiaries be required to pay increased premiums or cost sharing or be subject to a reduction in benefits under title XVIII of the Social Security Act as a result of such demonstration program. The Secretary shall ensure that any such demonstration program does not disadvantage those beneficiaries without reasonable access to high performing physicians or create financial inequities under such title.

(i) DEFINITIONS.—In this section:

(1) ELIGIBLE PROFESSIONAL.—The term ''eligible professional'' has the meaning given that term for purposes of the Physician Quality Reporting Initiative under section 1848 of the Social Security Act (42 U.S.C. 1395w–4)

(2) PHYSICIAN.—The term ''physician'' has the meaning given that term in section 1861(r) of such Act (42 U.S.C. 1395x(r)).

(3) PHYSICIAN COMPARE.—The term ''Physician Compare'' means the Internet website developed under subsection (a)(1).

(4) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

SEC. 10332. AVAILABILITY OF MEDICARE DATA FOR PERFORMANCE MEASUREMENT.

(a) IN GENERAL.—Section 1874 of the Social Security Act (42 U.S.C. 1395kk) is amended by adding at the end the following new subsection:

''(e) AVAILABILITY OF MEDICARE DATA.—

''(1) IN GENERAL.—Subject to paragraph (4), the Secretary shall make available to qualified entities (as defined in paragraph (2)) data described in paragraph (3) for the evaluation of the performance of providers of services and suppliers.

''(2) QUALIFIED ENTITIES.—For purposes of this subsection, the term 'qualified entity' means a public or private entity that—

''(A) is qualified (as determined by the Secretary) to use claims data to evaluate the performance of providers of services and suppliers on measures of quality, efficiency, effectiveness, and resource use; and

''(B) agrees to meet the requirements described in paragraph (4) and meets such other requirements as the Secretary may specify, such as ensuring security of data.

''(3) DATA DESCRIBED.—The data described in this paragraph are standardized extracts (as determined by the Secretary) of claims data under parts A, B, and D for items and services furnished under such parts for one or more specified geographic areas and time periods requested by a qualified entity. The Secretary shall take such actions as the Secretary deems necessary to protect the identity of individuals entitled to or enrolled for benefits under such parts.

''(4) REQUIREMENTS.—

''(A) FEE.—Data described in paragraph (3) shall be made available to a qualified entity under this subsection at a fee equal to the cost of making such data available. Any fee collected pursuant to the preceding sentence shall be deposited into the Federal Supplementary Medical Insurance Trust Fund under section 1841.

''(B) SPECIFICATION OF USES AND METHODOLOGIES.—A qualified entity requesting data under this subsection shall—

''(i) submit to the Secretary a description of the methodologies that such qualified entity will use to evaluate the performance of providers of services and suppliers using such data;

''(ii)(I) except as provided in subclause (II), if available, use standard measures, such as measures endorsed by the entity with a contract under section 1890(a) and measures developed pursuant to section 931 of the Public Health Service Act; or

''(II) use alternative measures if the Secretary, in consultation with appropriate stakeholders, determines that use of such alternative measures would be more valid, reliable, responsive to consumer preferences, cost-effective, or relevant to dimensions of quality and resource use not addressed by such standard measures;

''(iii) include data made available under this subsection with claims data from sources other than claims data under this title in the evaluation of performance of providers of services and suppliers;

''(iv) only include information on the evaluation of performance of providers and suppliers in reports described in subparagraph (C);

''(v) make available to providers of services and suppliers, upon their request, data made available under this subsection; and

''(vi) prior to their release, submit to the Secretary the format of reports under subparagraph (C).

''(C) REPORTS.—Any report by a qualified entity evaluating the performance of providers of services and suppliers using data made available under this subsection shall—

''(i) include an understandable description of the measures, which shall include quality measures and the rationale for use of other measures described in subparagraph (B)(ii)(II), risk adjustment methods, physician attribution methods, other applicable methods, data specifications and limitations, and the sponsors, so that consumers, providers of services and suppliers, health plans, researchers, and other stakeholders can assess such reports;

''(ii) be made available confidentially, to any provider of services or supplier to be identified in such report, prior to the public

release of such report, and provide an opportunity to appeal and correct errors;

''(iii) only include information on a provider of services or supplier in an aggregate form as determined appropriate by the Secretary; and

''(iv) except as described in clause (ii), be made available to the public.

''(D) APPROVAL AND LIMITATION OF USES.—The Secretary shall not make data described in paragraph (3) available to a qualified entity unless the qualified entity agrees to release the information on the evaluation of performance of providers of services and suppliers. Such entity shall only use such data, and information derived from such evaluation, for the reports under subparagraph (C). Data released to a qualified entity under this subsection shall not be subject to discovery or admission as evidence in judicial or administrative proceedings without consent of the applicable provider of services or supplier.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on January 1, 2012.

SEC. 10333. COMMUNITY-BASED COLLABORATIVE CARE NETWORKS.

Part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.) is amended by adding at the end the following new subpart:

"Subpart XI—Community-Based Collaborative Care Network Program

"SEC. 340H. COMMUNITY-BASED COLLABORATIVE CARE NETWORK PROGRAM.

''(a) IN GENERAL.—The Secretary may award grants to eligible entities to support community-based collaborative care networks that meet the requirements of subsection (b).

''(b) COMMUNITY-BASED COLLABORATIVE CARE NETWORKS.—

''(1) DESCRIPTION.—A community-based collaborative care network (referred to in this section as a 'network') shall be a consortium of health care providers with a joint governance structure (including providers within a single entity) that provides comprehensive coordinated and integrated health care services (as defined by the Secretary) for low-income populations.

''(2) REQUIRED INCLUSION.—A network shall include the following providers (unless such provider does not exist within the community, declines or refuses to participate, or places unreasonable conditions on their participation):

''(A) A hospital that meets the criteria in section 1923(b)(1) of the Social Security Act; and

''(B) All Federally qualified health centers (as defined in section 1861(aa) of the Social Security Act located in the community.

''(3) PRIORITY.—In awarding grants, the Secretary shall give priority to networks that include—

''(A) the capability to provide the broadest range of services to low-income individuals;

''(B) the broadest range of providers that currently serve a high volume of low-income individuals; and

''(C) a county or municipal department of health.

''(c) APPLICATION.—

''(1) APPLICATION.—A network described in subsection (b) shall submit an application to the Secretary.

''(2) RENEWAL.—In subsequent years, based on the performance of grantees, the Secretary may provide renewal grants to prior year grant recipients.

''(d) USE OF FUNDS.—

''(1) USE BY GRANTEES.—Grant funds may be used for the following activities:

''(A) Assist low-income individuals to—

''(i) access and appropriately use health services;

''(ii) enroll in health coverage programs; and

''(iii) obtain a regular primary care provider or a medical home.

''(B) Provide case management and care management.

''(C) Perform health outreach using neighborhood health workers or through other means.

''(D) Provide transportation.

''(E) Expand capacity, including through telehealth, after-hours services or urgent care.

''(F) Provide direct patient care services.

''(2) GRANT FUNDS TO HRSA GRANTEES.—The Secretary may limit the percent of grant funding that may be spent on direct care services provided by grantees of programs administered by the Health Resources and Services Administration or impose other requirements on such grantees deemed necessary.

''(e) 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 2011 through 2015.''.

SEC. 10334. MINORITY HEALTH.

(a) OFFICE OF MINORITY HEALTH.—

(1) IN GENERAL.—Section 1707 of the Public Health Service Act (42 U.S.C. 300u–6) is amended—

(A) in subsection (a), by striking ''within the Office of Public Health and Science'' and all that follows through the end and inserting ''. The Office of Minority Health as existing on the date of enactment of the Patient Protection and Affordable Care Act shall be transferred to the Office of the Secretary in such manner that there is established in the Office of the Secretary, the Office of Minority Health, which shall be headed by the Deputy Assistant Secretary for Minority Health who shall report directly to the Secretary, and shall retain and strengthen authorities (as in existence on such date of enactment) for the purpose of improving minority health and the quality of health care minorities receive, and eliminating racial and ethnic disparities. In carrying out this subsection, the Secretary, acting through the Deputy Assistant Secretary, shall award grants, contracts, enter into memoranda of understanding, cooperative, interagency, intra-agency and other agreements with public and nonprofit private entities, agencies, as well as Departmental and Cabinet agencies and organizations, and with organizations that are indigenous human resource providers in communities of color to assure improved health status of racial and ethnic minorities, and shall develop measures to evaluate the effectiveness of activities aimed at reducing health disparities and supporting the local community. Such measures shall evaluate community outreach activities, language services, workforce cultural competence, and other areas as determined by the Secretary.''; and

(B) by striking subsection (h) and inserting the following:

''(h) 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 2011 through 2016.''.

(2) TRANSFER OF FUNCTIONS.—There are transferred to the Office of Minority Health in the office of the Secretary of Health and Human Services, all duties, responsibilities, authorities, accountabilities, functions, staff, funds, award mechanisms, and other entities under the authority of the Office of Minority Health of the Public Health Service as in effect on the date before the date of enactment of this Act, which shall continue in effect according to the terms in effect on the date before such date of enactment, until modified, terminated, superseded, set aside, or revoked in accordance with law by the President, the Secretary, a court of competent jurisdiction, or by operation of law.

(3) REPORTS.—Not later than 1 year after the date of enactment of this section, and biennially thereafter, the Secretary of Health and Human Services shall prepare and submit to the appropriate committees of Congress a report describing the activities carried out under section 1707 of the Public Health Service Act (as amended by this subsection) during the period for which the report is being prepared. Not later than 1 year after the date of enactment of this section, and biennially thereafter, the heads of each of the agencies of the Department of Health and Human Services shall submit to the Deputy Assistant Secretary for Minority Health a report summarizing the minority health activities of each of the respective agencies.

(b) ESTABLISHMENT OF INDIVIDUAL OFFICES OF MINORITY HEALTH WITHIN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.—

(1) IN GENERAL.—Title XVII of the Public Health Service Act (42 U.S.C. 300u et seq.) is amended by inserting after section 1707 the following section:

"SEC. 1707A. INDIVIDUAL OFFICES OF MINORITY HEALTH WITHIN THE DEPARTMENT.

''(a) IN GENERAL.—The head of each agency specified in subsection (b)(1) shall establish within the agency an office to be known as the Office of Minority Health. The head of each such Office shall be appointed by the head of the agency within which the Office is established, and shall report directly to the head of the agency. The head of such agency shall carry out this section (as this section relates to the agency) acting through such Director.

''(b) SPECIFIED AGENCIES.—The agencies referred to in subsection (a) are the Centers for Disease Control and Prevention, the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration, the Agency for Healthcare Research and Quality, the Food and Drug Administration, and the Centers for Medicare & Medicaid Services.

''(c) DIRECTOR; APPOINTMENT.—Each Office of Minority Health established in an agency listed in subsection (a) shall be headed by a director, with documented experience and expertise in minority health services research and health disparities elimination.

''(d) REFERENCES.—Except as otherwise specified, any reference in Federal law to an Office of Minority Health (in the Department of Health and Human Services) is deemed to be a reference to the Office of Minority Health in the Office of the Secretary.

''(e) FUNDING.—

''(1) ALLOCATIONS.—Of the amounts appropriated for a specified agency for a fiscal year, the Secretary must designate an appropriate amount of funds for the purpose of carrying out activities under this section through the minority health office of the agency. In reserving an amount under the preceding sentence for a minority health office for a fiscal year, the Secretary shall reduce, by substantially the same percentage, the amount that otherwise would be available for each of the programs of the designated agency involved.

''(2) AVAILABILITY OF FUNDS FOR STAFFING.—The purposes for which amounts made available under paragraph may be expended by a minority health office include the costs of employing staff for such office.''.

(2) NO NEW REGULATORY AUTHORITY.—Nothing in this subsection and the amendments made by this subsection may be construed as establishing regulatory authority or modifying any existing regulatory authority.

(3) LIMITATION ON TERMINATION.—Notwithstanding any other provision of law, a Federal office of minority health or Federal appointive position with primary responsibility over minority health issues that is in existence in an office of agency of the Department of Health and Human Services on the date of enactment of this section shall not be terminated, reorganized, or have any of its power or duties transferred unless such termination, reorganization, or transfer is approved by an Act of Congress.

(c) REDESIGNATION OF NATIONAL CENTER ON MINORITY HEALTH AND HEALTH DISPARITIES.—

(1) REDESIGNATION.—Title IV of the Public Health Service Act (42 U.S.C. 281 et seq.) is amended—

(A) by redesignating subpart 6 of part E as subpart 20;

(B) by transferring subpart 20, as so redesignated, to part C of such title IV;

(C) by inserting subpart 20, as so redesignated, after subpart 19 of such part C; and

(D) in subpart 20, as so redesignated—

(i) by redesignating sections 485E through 485H as sections 464z–3 through 464z–6, respectively;

(ii) by striking ''National Center on Minority Health and Health Disparities'' each place such term appears and inserting ''National Institute on Minority Health and Health Disparities''; and

(iii) by striking ''Center'' each place such term appears and inserting ''Institute''.

(2) PURPOSE OF INSTITUTE; DUTIES.—Section 464z–3 of the Public Health Service Act, as so redesignated, is amended—

(A) in subsection (h)(1), by striking ''research endowments at centers of excellence under section 736.'' and inserting the following: ''research endowments—

''(1) at centers of excellence under section 736; and

''(2) at centers of excellence under section 464z-4.'';

(B) in subsection (h)(2)(A), by striking ''average'' and inserting ''median''; and

(C) by adding at the end the following:

''(h) INTERAGENCY COORDINATION.—The Director of the Institute, as the primary Federal officials with responsibility for coordinating all research and activities conducted or supported by the National Institutes of Health on minority health and health disparities, shall plan, coordinate, review and evaluate research and other activities conducted or supported by the Institutes and Centers of the National Institutes of Health.''.

(3) TECHNICAL AND CONFORMING AMENDMENTS.—

(A) Section 401(b)(24) of the Public Health Service Act (42 U.S.C. 281(b)(24)) is amended by striking ''Center'' and inserting ''Institute''.

(B) Subsection (d)(1) of section 903 of the Public Health Service Act (42 U.S.C. 299a-1(d)(1)) is amended by striking ''section 485E'' and inserting ''section 464z–3''.

SEC. 10335. TECHNICAL CORRECTION TO THE HOSPITAL VALUE-BASED PURCHASING PROGRAM.

Section 1886(o)(2)A) of the Social Security Act, as added by section 3001, is amended, in the first sentence, by inserting '', other than measures of readmissions,'' after ''shall select measures''.

SEC. 10336. GAO STUDY AND REPORT ON MEDICARE BENEFICIARY ACCESS TO HIGH-QUALITY DIALYSIS SERVICES.

(a) STUDY.—

(1) IN GENERAL.—The Comptroller General of the United States shall conduct a study on the impact on Medicare beneficiary access to high-quality dialysis services of including specified oral drugs that are furnished to such beneficiaries for the treatment of end stage renal disease in the bundled prospective payment system under section 1881(b)(14) of the Social Security Act (42 U.S.C. 1395rr(b)(14)) (pursuant to the proposed rule published by the Secretary of Health and Human Services in the Federal Register on September 29, 2009 (74 Fed. Reg. 49922 et seq.)). Such study shall include an analysis of—

(A) the ability of providers of services and renal dialysis facilities to furnish specified oral drugs or arrange for the provision of such drugs;

(B) the ability of providers of services and renal dialysis facilities to comply, if necessary, with applicable State laws (such as State pharmacy licensure requirements) in order to furnish specified oral drugs;

(C) whether appropriate quality measures exist to safeguard care for Medicare beneficiaries being furnished specified oral drugs by providers of services and renal dialysis facilities; and

(D) other areas determined appropriate by the Comptroller General.

(2) SPECIFIED ORAL DRUG DEFINED.—For purposes of paragraph (1), the term ''specified oral drug'' means a drug or biological for which there is no injectable equivalent (or other non-oral form of administration).

(b) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Comptroller General of the United States 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.

Subtitle D—Provisions Relating to Title IV

SEC. 10401. AMENDMENTS TO SUBTITLE A.

(a) Section 4001(h)(4) and (5) of this Act is amended by striking ''2010'' each place such appears and inserting ''2020''.

(b) Section 4002(c) of this Act is amended—

(1) by striking ''research and health screenings'' and inserting ''research, health screenings, and initiatives''; and

(2) by striking ''for Preventive'' and inserting ''Regarding Preventive''.

(c) Section 4004(a)(4) of this Act is amended by striking ''a Gateway'' and inserting ''an Exchange''.

SEC. 10402. AMENDMENTS TO SUBTITLE B.

(a) Section 399Z-1(a)(1(A) of the Public Health Service Act, as added by section 4101(b) of this Act, is amended by inserting ''and vision'' after ''oral''.

(b) Section 1861(hhh)(4)(G) of the Social Security Act, as added by section 4103(b), is amended to read as follows:

''(G) A beneficiary shall be eligible to receive only an initial preventive physical examination (as defined under subsection (ww)(1)) 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 each year thereafter provided that the beneficiary has not received either an initial preventive physical examination or personalized prevention plan services within the preceding 12-month period.''.

SEC. 10403. AMENDMENTS TO SUBTITLE C.

Section 4201 of this Act is amended—

(1) in subsection (a), by adding before the period the following: '', with not less than 20 percent of such grants being awarded to rural and frontier areas'';

(2) in subsection (c)(2)(B)(vii), by striking ''both urban and rural areas'' and inserting ''urban, rural, and frontier areas''; and

(3) in subsection (f), by striking ''each fiscal years'' and inserting ''each of fiscal year''.

SEC. 10404. AMENDMENTS TO SUBTITLE D.

Section 399MM(2) of the Public Health Service Act, as added by section 4303 of this Act, is amended by striking ''by ensuring'' and inserting ''and ensuring''.

SEC. 10405. AMENDMENTS TO SUBTITLE E.

Subtitle E of title IV of this Act is amended by striking section 4401.

SEC. 10406. AMENDMENT RELATING TO WAIVING COINSURANCE FOR PREVENTIVE SERVICES.

Section 4104(b) of this Act is amended to read as follows:

''(b) PAYMENT AND ELIMINATION OF COINSURANCE IN ALL SETTINGS.—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)), as amended by section 4103(c)(1), is amended—

''(1) in subparagraph (T), by inserting '(or 100 percent if such services 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)' after '80 percent';

''(2) in subparagraph (W)—

''(A) in clause (i), by inserting '(if such subparagraph were applied, by substituting ''100 percent'' for ''80 percent'')' after 'subparagraph (D)'; and

''(B) in clause (ii), by striking '80 percent' and inserting '100 percent';

''(3) by striking 'and' before '(X)'; and

''(4) by inserting before the semicolon at the end the following: ', and (Y) with 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 (i) except as provided in clause (ii), 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, and (ii) in the case of such services that are covered OPD services (as defined in subsection (t)(1)(B)), the amount determined under subsection (t)'.''.

SEC. 10407. BETTER DIABETES CARE.

(a) SHORT TITLE.—This section may be cited as the ''Catalyst to Better Diabetes Care Act of 2009''.

(b) NATIONAL DIABETES REPORT CARD.—

(1) IN GENERAL.—The Secretary, in collaboration with the Director of the Centers for Disease Control and Prevention (referred to in this section as the ''Director''), shall prepare on a biennial basis a national diabetes report card (referred to in this section as a ''Report Card'') and, to the extent possible, for each State.

(2) CONTENTS.—

(A) IN GENERAL.—Each Report Card shall include aggregate health outcomes related to individuals diagnosed with diabetes and prediabetes including—

(i) preventative care practices and quality of care;

(ii) risk factors; and

(iii) outcomes.

(B) UPDATED REPORTS.—Each Report Card that is prepared after the initial Report Card shall include trend analysis for the Nation and, to the extent possible, for each State, for the purpose of—

(i) tracking progress in meeting established national goals and objectives for improving diabetes care, costs, and prevalence (including Healthy People 2010); and

(ii) informing policy and program development.

(3) AVAILABILITY.—The Secretary, in collaboration with the Director, shall make each Report Card publicly available, including by posting the Report Card on the Internet.

(c) IMPROVEMENT OF VITAL STATISTICS COLLECTION.—

(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention and in collaboration with appropriate agencies and States, shall—

(A) promote the education and training of physicians on the importance of birth and death certificate data and how to properly complete these documents, including the collection of such data for diabetes and other chronic diseases;

(B) encourage State adoption of the latest standard revisions of birth and death certificates; and

(C) work with States to re-engineer their vital statistics systems in order to provide cost-effective, timely, and accurate vital systems data.

(2) DEATH CERTIFICATE ADDITIONAL LANGUAGE.—In carrying out this subsection, the Secretary may promote improvements to the collection of diabetes mortality data, including the addition of a question for the individual certifying the cause of death regarding whether the deceased had diabetes.

(d) STUDY ON APPROPRIATE LEVEL OF DIABETES MEDICAL EDUCATION.—

(1) IN GENERAL.—The Secretary shall, in collaboration with the Institute of Medicine and appropriate associations and councils, conduct a study of the impact of diabetes on the practice of medicine in the United States and the appropriateness of the level of diabetes medical education that should be required prior to licensure, board certification, and board recertification.

(2) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall submit a report on the study under paragraph (1) to the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committees on Finance and Health, Education, Labor, and Pensions of the Senate.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary.

SEC. 10408. GRANTS FOR SMALL BUSINESSES TO PROVIDE COMPREHENSIVE WORKPLACE WELLNESS PROGRAMS.

(a) ESTABLISHMENT.—The Secretary shall award grants to eligible employers to provide their employees with access to comprehensive workplace wellness programs (as described under subsection (c)).

(b) SCOPE.—

(1) DURATION.—The grant program established under this section shall be conducted for a 5-year period.

(2) ELIGIBLE EMPLOYER.—The term ''eligible employer'' means an employer (including a non-profit employer) that—

(A) employs less than 100 employees who work 25 hours or greater per week; and

(B) does not provide a workplace wellness program as of the date of enactment of this Act.

(c) COMPREHENSIVE WORKPLACE WELLNESS PROGRAMS.—

(1) CRITERIA.—The Secretary shall develop program criteria for comprehensive workplace wellness programs under this section that are based on and consistent with evidence-based research and best practices, including research and practices as provided in the Guide to Community Preventive Services, the Guide to Clinical Preventive Services, and the National Registry for Effective Programs.

(2) REQUIREMENTS.—A comprehensive workplace wellness program shall be made available by an eligible employer to all employees and include the following components:

(A) Health awareness initiatives (including health education, preventive screenings, and health risk assessments).

(B) Efforts to maximize employee engagement (including mechanisms to encourage employee participation).

(C) Initiatives to change unhealthy behaviors and lifestyle choices (including counseling, seminars, online programs, and self-help materials).

(D) Supportive environment efforts (including workplace policies to encourage healthy lifestyles, healthy eating, increased physical activity, and improved mental health).

(d) APPLICATION.—An eligible employer desiring to participate in the grant program under this section shall submit an application to the Secretary, in such manner and containing such information as the Secretary may require, which shall include a proposal for a comprehensive workplace wellness program that meet the criteria and requirements described under subsection (c).

(e) AUTHORIZATION OF APPROPRIATION.—For purposes of carrying out the grant program under this section, there is authorized to be appropriated $200,000,000 for the period of fiscal years 2011 through 2015. Amounts appropriated pursuant to this subsection shall remain available until expended.

SEC. 10409. CURES ACCELERATION NETWORK.

(a) SHORT TITLE.—This section may be cited as the ''Cures Acceleration Network Act of 2009''.

(b) REQUIREMENT FOR THE DIRECTOR OF NIH TO ESTABLISH A CURES ACCELERATION NETWORK.—Section 402(b) of the Public Health Service Act (42 U.S.C. 282(b)) is amended—

(1) in paragraph (22), by striking ''and'' at the end;

(2) in paragraph (23), by striking the period and inserting ''; and''; and

(3) by inserting after paragraph (23), the following:

''(24) implement the Cures Acceleration Network described in section 402C.''.

(c) ACCEPTING GIFTS TO SUPPORT THE CURES ACCELERATION NETWORK.—Section 499(c)(1) of the Public Health Service Act (42 U.S.C. 290b(c)(1)) is amended by adding at the end the following:

''(E) The Cures Acceleration Network described in section 402C.''.

(d) ESTABLISHMENT OF THE CURES ACCELERATION NETWORK.—Part A of title IV of the Public Health Service Act is amended by inserting after section 402B (42 U.S.C. 282b) the following:

''SEC. 402C. CURES ACCELERATION NETWORK.

''(a) DEFINITIONS.—In this section:

''(1) BIOLOGICAL PRODUCT.—The term 'biological product' has the meaning given such term in section 351 of the Public Health Service Act.

''(2) DRUG; DEVICE.—The terms 'drug' and 'device' have the meanings given such terms in section 201 of the Federal Food, Drug, and Cosmetic Act.

''(3) HIGH NEED CURE.—The term 'high need cure' means a drug (as that term is defined by section 201(g)(1) of the Federal Food, Drug, and Cosmetic Act, biological product (as that term is defined by section 262(i)), or device (as that term is defined by section 201(h) of the Federal Food, Drug, and Cosmetic Act) that, in the determination of the Director of NIH—

''(A) is a priority to diagnose, mitigate, prevent, or treat harm from any disease or condition; and

''(B) for which the incentives of the commercial market are unlikely to result in its adequate or timely development.

''(4) MEDICAL PRODUCT.—The term 'medical product' means a drug, device, biological product, or product that is a combination of drugs, devices, and biological products.

''(b) ESTABLISHMENT OF THE CURES ACCELERATION NETWORK.—Subject to the appropriation of funds as described in subsection (g), there is established within the Office of the Director of NIH a program to be known as the Cures Acceleration Network (referred to in this section as 'CAN'), which shall—

''(1) be under the direction of the Director of NIH, taking into account the recommendations of a CAN Review Board (referred to in this section as the 'Board'), described in subsection (d); and

''(2) award grants and contracts to eligible entities, as described in subsection (e), to accelerate the development of high need cures, including through the development of medical products and behavioral therapies.

''(c) FUNCTIONS.—The functions of the CAN are to—

''(1) conduct and support revolutionary advances in basic research, translating scientific discoveries from bench to bedside;

''(2) award grants and contracts to eligible entities to accelerate the development of high need cures;

''(3) provide the resources necessary for government agencies, independent investigators, research organizations, biotechnology companies, academic research institutions, and other entities to develop high need cures;

''(4) reduce the barriers between laboratory discoveries and clinical trials for new therapies; and

''(5) facilitate review in the Food and Drug Administration for the high need cures funded by the CAN, through activities that may include—

''(A) the facilitation of regular and ongoing communication with the Food and Drug Administration regarding the status of activities conducted under this section;

''(B) ensuring that such activities are coordinated with the approval requirements of the Food and Drug Administration, with the goal of expediting the development and approval of countermeasures and products; and

''(C) connecting interested persons with additional technical assistance made available under section 565 of the Federal Food, Drug, and Cosmetic Act.

''(d) CAN BOARD.—

''(1) ESTABLISHMENT.—There is established a Cures Acceleration Network Review Board (referred to in this section as the 'Board'), which shall advise the Director of NIH on the conduct of the activities of the Cures Acceleration Network.

''(2) MEMBERSHIP.—

''(A) IN GENERAL.—

''(i) APPOINTMENT.—The Board shall be comprised of 24 members who are appointed by the Secretary and who serve at the pleasure of the Secretary.

''(ii) CHAIRPERSON AND VICE CHAIRPERSON.—The Secretary shall designate, from among the 24 members appointed under clause (i), one Chairperson of the Board (referred to in this section as the 'Chairperson') and one Vice Chairperson.

''(B) TERMS.—

''(i) IN GENERAL.—Each member shall be appointed to serve a 4-year term, except that any member appointed to fill a vacancy occurring prior to the expiration of the term for which the member's predecessor was appointed shall be appointed for the remainder of such term.

''(ii) CONSECUTIVE APPOINTMENTS; MAXIMUM TERMS.—A member may be appointed to serve not more than 3 terms on the Board, and may not serve more than 2 such terms consecutively.

''(C) QUALIFICATIONS.—

''(i) IN GENERAL.—The Secretary shall appoint individuals to the Board based solely upon the individual's established record of distinguished service in one of the areas of

expertise described in clause (ii). Each individual appointed to the Board shall be of distinguished achievement and have a broad range of disciplinary interests.

''(ii) EXPERTISE.—The Secretary shall select individuals based upon the following requirements:

''(I) For each of the fields of—

''(aa) basic research;

''(bb) medicine;

''(cc) biopharmaceuticals;

''(dd) discovery and delivery of medical products;

''(ee) bioinformatics and gene therapy;

''(ff) medical instrumentation; and

''(gg) regulatory review and approval of medical products,

the Secretary shall select at least 1 individual who is eminent in such fields.

''(II) At least 4 individuals shall be recognized leaders in professional venture capital or private equity organizations and have demonstrated experience in private equity investing.

''(III) At least 8 individuals shall represent disease advocacy organizations.

''(3) EX-OFFICIO MEMBERS.—

''(A) APPOINTMENT.—In addition to the 24 Board members described in paragraph (2), the Secretary shall appoint as ex-officio members of the Board—

''(i) a representative of the National Institutes of Health, recommended by the Secretary of the Department of Health and Human Services;

''(ii) a representative of the Office of the Assistant Secretary of Defense for Health Affairs, recommended by the Secretary of Defense;

''(iii) a representative of the Office of the Under Secretary for Health for the Veterans Health Administration, recommended by the Secretary of Veterans Affairs;

''(iv) a representative of the National Science Foundation, recommended by the Chair of the National Science Board; and

''(v) a representative of the Food and Drug Administration, recommended by the Commissioner of Food and Drugs.

''(B) TERMS.—Each ex-officio member shall serve a 3-year term on the Board, except that the Chairperson may adjust the terms of the initial ex-officio members in order to provide for a staggered term of appointment for all such members.

''(4) RESPONSIBILITIES OF THE BOARD AND THE DIRECTOR OF NIH.—

''(A) RESPONSIBILITIES OF THE BOARD.—

''(i) IN GENERAL.—The Board shall advise, and provide recommendations to, the Director of NIH with respect to—

''(I) policies, programs, and procedures for carrying out the duties of the Director of NIH under this section; and

''(II) significant barriers to successful translation of basic science into clinical application (including issues under the purview of other agencies and departments).

''(ii) REPORT.—In the case that the Board identifies a significant barrier, as described in clause (i)(II), the Board shall submit to the Secretary a report regarding such barrier.

''(B) RESPONSIBILITIES OF THE DIRECTOR OF NIH.—With respect to each recommendation provided by the Board under subparagraph (A)(i), the Director of NIH shall respond in writing to the Board, indicating whether such Director will implement such recommendation. In the case that the Director of NIH indicates a recommendation of the Board will not be implemented, such Director shall provide an explanation of the reasons for not implementing such recommendation.

''(5) MEETINGS.—

''(A) IN GENERAL.—The Board shall meet 4 times per calendar year, at the call of the Chairperson.

''(B) QUORUM; REQUIREMENTS; LIMITATIONS.—

''(i) QUORUM.—A quorum shall consist of a total of 13 members of the Board, excluding ex-officio members, with diverse representation as described in clause (iii).

''(ii) CHAIRPERSON OR VICE CHAIRPERSON.—Each meeting of the Board shall be attended by either the Chairperson or the Vice Chairperson.

''(iii) DIVERSE REPRESENTATION.—At each meeting of the Board, there shall be not less than one scientist, one representative of a disease advocacy organization, and one representative of a professional venture capital or private equity organization.

''(6) COMPENSATION AND TRAVEL EXPENSES.—

''(A) COMPENSATION.—Members shall receive compensation at a rate to be fixed by the Chairperson but not to exceed a rate equal to the daily equivalent of the annual rate of basic pay prescribed for level IV of the Executive Schedule under section 5315 of title 5, United States Code, for each day (including travel time) during which the member is engaged in the performance of the duties of the Board. All members of the Board who are officers or employees of the Untied States shall serve without compensation in addition to that received for their services as officers or employees of the United States.

''(B) TRAVEL EXPENSES.—Members of the Board shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for persons employed intermittently by the Federal Government under section 5703(b) of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Board.

''(e) GRANT PROGRAM.—

''(1) SUPPORTING INNOVATION.—To carry out the purposes described in this section, the Director of NIH shall award contracts, grants, or cooperative agreements to the entities described in paragraph (2), to—

''(A) promote innovation in technologies supporting the advanced research and development and production of high need cures, including through the development of medical products and behavioral therapies.

''(B) accelerate the development of high need cures, including through the development of medical products, behavioral therapies, and biomarkers that demonstrate the safety or effectiveness of medical products; or

''(C) help the award recipient establish protocols that comply with Food and Drug Administration standards and otherwise permit the recipient to meet regulatory requirements at all stages of development, manufacturing, review, approval, and safety surveillance of a medical product.

''(2) ELIGIBLE ENTITIES.—To receive assistance under paragraph (1), an entity shall—

''(A) be a public or private entity, which may include a private or public research institution, an institution of higher education, a medical center, a biotechnology company, a pharmaceutical company, a disease advocacy organization, a patient advocacy organization, or an academic research institution;

''(B) submit an application containing—

''(i) a detailed description of the project for which the entity seeks such grant or contract;

''(ii) a timetable for such project;

''(iii) an assurance that the entity will submit—

''(I) interim reports describing the entity's—

''(aa) progress in carrying out the project; and

''(bb) compliance with all provisions of this section and conditions of receipt of such grant or contract; and

''(II) a final report at the conclusion of the grant period, describing the outcomes of the project; and

''(iv) a description of the protocols the entity will follow to comply with Food and Drug Administration standards and regulatory requirements at all stages of development, manufacturing, review, approval, and safety surveillance of a medical product; and

''(C) provide such additional information as the Director of NIH may require.

''(3) AWARDS.—

''(A) THE CURES ACCELERATION PARTNERSHIP AWARDS.—

''(i) INITIAL AWARD AMOUNT.—Each award under this subparagraph shall be not more than $15,000,000 per project for the first fiscal year for which the project is funded, which shall be payable in one payment.

''(ii) FUNDING IN SUBSEQUENT FISCAL YEARS.—An eligible entity receiving an award under clause (i) may apply for additional funding for such project by submitting to the Director of NIH the information required under subparagraphs (B) and (C) of paragraph (2). The Director may fund a project of such eligible entity in an amount not to exceed $15,000,000 for a fiscal year subsequent to the initial award under clause (i).

''(iii) MATCHING FUNDS.—As a condition for receiving an award under this subsection, an eligible entity shall contribute to the project non-Federal funds in the amount of $1 for every $3 awarded under clauses (i) and (ii), except that the Director of NIH may waive or modify such matching requirement in any case where the Director determines that the goals and objectives of this section cannot adequately be carried out unless such requirement is waived.

''(B) THE CURES ACCELERATION GRANT AWARDS.—

''(i) INITIAL AWARD AMOUNT.—Each award under this subparagraph shall be not more than $15,000,000 per project for the first fiscal year for which the project is funded, which shall be payable in one payment.

''(ii) FUNDING IN SUBSEQUENT FISCAL YEARS.—An eligible entity receiving an award under clause (i) may apply for additional funding for such project by submitting to the Board the information required under subparagraphs (B) and (C) of paragraph (2). The Director of NIH may fund a project of such eligible entity in an amount not to exceed $15,000,000 for a fiscal year subsequent to the initial award under clause (i).

''(C) THE CURES ACCELERATION FLEXIBLE RESEARCH AWARDS.—If the Director of NIH determines that the goals and objectives of this section cannot adequately be carried out through a contract, grant, or cooperative agreement, the Director of NIH shall have flexible research authority to use other transactions to fund projects in accordance with the terms and conditions of this section. Awards made under such flexible research authority for a fiscal year shall not exceed 20 percent of the total funds appropriated under subsection (g)(1) for such fiscal year.

''(4) SUSPENSION OF AWARDS FOR DEFAULTS, NONCOMPLIANCE WITH PROVISIONS AND PLANS, AND DIVERSION OF FUNDS; REPAYMENT OF FUNDS.—The Director of NIH may suspend the award to any entity upon noncompliance by such entity with provisions and plans under this section or diversion of funds.

''(5) AUDITS.—The Director of NIH may enter into agreements with other entities to conduct periodic audits of the projects funded by grants or contracts awarded under this subsection.

''(6) CLOSEOUT PROCEDURES.—At the end of a grant or contract period, a recipient shall follow the closeout procedures under section 74.71 of title 45, Code of Federal Regulations (or any successor regulation).

''(7) REVIEW.—A determination by the Director of NIH as to whether a drug, device, or biological product is a high need cure (for purposes of subsection (a)(3)) shall not be subject to judicial review.

''(f) COMPETITIVE BASIS OF AWARDS.—Any grant, cooperative agreement, or contract awarded under this section shall be awarded on a competitive basis.

''(g) AUTHORIZATION OF APPROPRIATIONS.—

''(1) IN GENERAL.—For purposes of carrying out this section, there are authorized to be appropriated $500,000,000 for fiscal year 2010, and such sums as may be necessary for subsequent fiscal years. Funds appropriated under this section shall be available until expended.

''(2) LIMITATION ON USE OF FUNDS OTHERWISE APPROPRIATED.—No funds appropriated under this Act, other than funds appropriated under paragraph (1), may be allocated to the Cures Acceleration Network.''.

SEC. 10410. CENTERS OF EXCELLENCE FOR DEPRESSION.

(a) SHORT TITLE.—This section may be cited as the ''Establishing a Network of Health-Advancing National Centers of Excellence for Depression Act of 2009'' or the ''ENHANCED Act of 2009''.

(b) CENTERS OF EXCELLENCE FOR DEPRESSION.—Subpart 3 of part B of title V of the Public Health Service Act (42 U.S.C. 290bb et seq.) is amended by inserting after section 520A the following:

''SEC. 520B. NATIONAL CENTERS OF EXCELLENCE FOR DEPRESSION.

''(a) DEPRESSIVE DISORDER DEFINED.—In this section, the term 'depressive disorder' means a mental or brain disorder relating to depression, including major depression, bipolar disorder, and related mood disorders.

''(b) GRANT PROGRAM.—

''(1) IN GENERAL.—The Secretary, acting through the Administrator, shall award grants on a competitive basis to eligible entities to establish national centers of excellence for depression (referred to in this section as 'Centers'), which shall engage in activities related to the treatment of depressive disorders.

''(2) ALLOCATION OF AWARDS.—If the funds authorized under subsection (f) are appropriated in the amounts provided for under such subsection, the Secretary shall allocate such amounts so that—

''(A) not later than 1 year after the date of enactment of the ENHANCED Act of 2009, not more than 20 Centers may be established; and

''(B) not later than September 30, 2016, not more than 30 Centers may be established.

''(3) GRANT PERIOD.—

''(A) IN GENERAL.—A grant awarded under this section shall be for a period of 5 years.

''(B) RENEWAL.—A grant awarded under subparagraph (A) may be renewed, on a competitive basis, for 1 additional 5-year period, at the discretion of the Secretary. In determining whether to renew a grant, the Secretary shall consider the report cards issued under subsection (e)(2).

''(4) USE OF FUNDS.—Grant funds awarded under this subsection shall be used for the establishment and ongoing activities of the recipient of such funds.

''(5) ELIGIBLE ENTITIES.—

''(A) REQUIREMENTS.—To be eligible to receive a grant under this section, an entity shall—

''(i) be an institution of higher education or a public or private nonprofit research institution; and

''(ii) submit an application to the Secretary at such time and in such manner as the Secretary may require, as described in subparagraph (B).

''(B) APPLICATION.—An application described in subparagraph (A)(ii) shall include—

''(i) evidence that such entity—

''(I) provides, or is capable of coordinating with other entities to provide, comprehensive health services with a focus on mental health services and subspecialty expertise for depressive disorders;

''(II) collaborates with other mental health providers, as necessary, to address co-occurring mental illnesses;

''(III) is capable of training health professionals about mental health; and

''(ii) such other information, as the Secretary may require.

''(C) PRIORITIES.—In awarding grants under this section, the Secretary shall give priority to eligible entities that meet 1 or more of the following criteria:

''(i) Demonstrated capacity and expertise to serve the targeted population.

''(ii) Existing infrastructure or expertise to provide appropriate, evidence-based and culturally and linguistically competent services.

''(iii) A location in a geographic area with disproportionate numbers of underserved and at-risk populations in medically underserved areas and health professional shortage areas.

''(iv) Proposed innovative approaches for outreach to initiate or expand services.

''(v) Use of the most up-to-date science, practices, and interventions available.

''(vi) Demonstrated capacity to establish cooperative and collaborative agreements with community mental health centers and other community entities to provide mental health, social, and human services to individuals with depressive disorders.

''(6) NATIONAL COORDINATING CENTER.—

''(A) IN GENERAL.—The Secretary, acting through the Administrator, shall designate 1 recipient of a grant under this section to be the coordinating center of excellence for depression (referred to in this section as the 'coordinating center'). The Secretary shall select such coordinating center on a competitive basis, based upon the demonstrated capacity of such center to perform the duties described in subparagraph (C).

''(B) APPLICATION.—A Center that has been awarded a grant under paragraph (1) may apply for designation as the coordinating center by submitting an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

''(C) DUTIES.—The coordinating center shall—

''(i) develop, administer, and coordinate the network of Centers under this section;

''(ii) oversee and coordinate the national database described in subsection (d);

''(iii) lead a strategy to disseminate the findings and activities of the Centers through such database; and

''(iv) serve as a liaison with the Administration, the National Registry of Evidence-based Programs and Practices of the Administration, and any Federal interagency or interagency forum on mental health.

''(7) MATCHING FUNDS.—The Secretary may not award a grant or contract under this section to an entity unless the entity agrees that it will make available (directly or through contributions from other public or private entities) non-Federal contributions toward the activities to be carried out under the grant or contract in an amount equal to $1 for each $5 of Federal funds provided under the grant or contract. Such non-Federal matching funds may be provided directly or through donations from public or private entities and may be in cash or in-kind, fairly evaluated, including plant, equipment, or services.

''(c) ACTIVITIES OF THE CENTERS.—Each Center shall carry out the following activities:

''(1) GENERAL ACTIVITIES.—Each Center shall—

''(A) integrate basic, clinical, or health services interdisciplinary research and practice in the development, implementation, and dissemination of evidence-based interventions;

''(B) involve a broad cross-section of stakeholders, such as researchers, clinicians, consumers, families of consumers, and voluntary health organizations, to develop a research agenda and disseminate findings, and to provide support in the implementation of evidence-based practices;

''(C) provide training and technical assistance to mental health professionals, and engage in and disseminate translational research with a focus on meeting the needs of individuals with depressive disorders; and

''(D) educate policy makers, employers, community leaders, and the public about depressive disorders to reduce stigma and raise awareness of treatments.

''(2) IMPROVED TREATMENT STANDARDS, CLINICAL GUIDELINES, DIAGNOSTIC PROTOCOLS, AND CARE COORDINATION PRACTICE.—Each Center shall collaborate with other Centers in the network to—

''(A) develop and implement treatment standards, clinical guidelines, and protocols that emphasize primary prevention, early intervention, treatment for, and recovery from, depressive disorders;

''(B) foster communication with other providers attending to co-occurring physical health conditions such as cardiovascular, diabetes, cancer, and substance abuse disorders;

''(C) leverage available community resources, develop and implement improved self-management programs, and, when appropriate, involve family and other providers of social support in the development and implementation of care plans; and

''(D) use electronic health records and telehealth technology to better coordinate and manage, and improve access to, care, as determined by the coordinating center.

''(3) TRANSLATIONAL RESEARCH THROUGH COLLABORATION OF CENTERS AND COMMUNITY-BASED ORGANIZATIONS.—Each Center shall—

''(A) demonstrate effective use of a public-private partnership to foster collaborations among members of the network and community-based organizations such as community mental health centers and other social and human services providers;

''(B) expand interdisciplinary, translational, and patient-oriented research and treatment; and

''(C) coordinate with accredited academic programs to provide ongoing opportunities for the professional and continuing education of mental health providers.

''(d) NATIONAL DATABASE.—

''(1) IN GENERAL.—The coordinating center shall establish and maintain a national, publicly available database to improve prevention programs, evidence-based interventions, and disease management programs for depressive disorders, using data collected from the Centers, as described in paragraph (2).

''(2) DATA COLLECTION.—Each Center shall submit data gathered at such center, as appropriate, to the coordinating center regarding—

''(A) the prevalence and incidence of depressive disorders;

''(B) the health and social outcomes of individuals with depressive disorders;

''(C) the effectiveness of interventions designed, tested, and evaluated;

''(D) other information, as the Secretary may require.

''(3) SUBMISSION OF DATA TO THE ADMINISTRATOR.—The coordinating center shall submit to the Administrator the data and financial information gathered under paragraph (2).

''(4) PUBLICATION USING DATA FROM THE DATABASE.—A Center, or an individual affiliated with a Center, may publish findings using the data described in paragraph (2) only if such center submits such data to the coordinating center, as required under such paragraph.

''(e) ESTABLISHMENT OF STANDARDS; REPORT CARDS AND RECOMMENDATIONS; THIRD PARTY REVIEW.—

''(1) ESTABLISHMENT OF STANDARDS.—The Secretary, acting through the Administrator, shall establish performance standards for—

''(A) each Center; and

''(B) the network of Centers as a whole.

''(2) REPORT CARDS.—The Secretary, acting through the Administrator, shall—

''(A) for each Center, not later than 3 years after the date on which such center of excellence is established and annually thereafter, issue a report card to the coordinating center to rate the performance of such Center; and

''(B) not later than 3 years after the date on which the first grant is awarded under subsection (b)(1) and annually thereafter, issue a report card to Congress to rate the performance of the network of centers of excellence as a whole.

''(3) RECOMMENDATIONS.—Based upon the report cards described in paragraph (2), the Secretary shall, not later than September 30, 2015—

''(A) make recommendations to the Centers regarding improvements such centers shall make; and

''(B) make recommendations to Congress for expanding the Centers to serve individuals with other types of mental disorders.

''(4) THIRD PARTY REVIEW.—Not later than 3 years after the date on which the first grant is awarded under subsection (b)(1) and annually thereafter, the Secretary shall arrange for an independent third party to conduct an evaluation of the network of Centers to ensure that such centers are meeting the goals of this section.

''(f) AUTHORIZATION OF APPROPRIATIONS.—

''(1) IN GENERAL.—To carry out this section, there are authorized to be appropriated—

''(A) $100,000,000 for each of the fiscal years 2011 through 2015; and

''(B) $150,000,000 for each of the fiscal years 2016 through 2020.

''(2) ALLOCATION OF FUNDS AUTHORIZED.—Of the amount appropriated under paragraph (1) for a fiscal year, the Secretary shall determine the allocation of each Center receiving a grant under this section, but in no case may the allocation be more than $5,000,000, except that the Secretary may allocate not more than $10,000,000 to the coordinating center.''.

SEC. 10411. PROGRAMS RELATING TO CONGENITAL HEART DISEASE.

(a) SHORT TITLE.—This subtitle may be cited as the ''Congenital Heart Futures Act''.

(b) PROGRAMS RELATING TO CONGENITAL HEART DISEASE.—

(1) NATIONAL CONGENITAL HEART DISEASE SURVEILLANCE SYSTEM.—Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.), as amended by section 5405, is further amended by adding at the end the following:

''SEC. 399V-2. NATIONAL CONGENITAL HEART DISEASE SURVEILLANCE SYSTEM.

''(a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, may—

''(1) enhance and expand infrastructure to track the epidemiology of congenital heart disease and to organize such information into a nationally-representative, population-based surveillance system that compiles data concerning actual occurrences of congenital heart disease, to be known as the 'National Congenital Heart Disease Surveillance System'; or

''(2) award a grant to one eligible entity to undertake the activities described in paragraph (1).

''(b) PURPOSE.—The purpose of the Congenital Heart Disease Surveillance System shall be to facilitate further research into the types of health services patients use and to identify possible areas for educational outreach and prevention in accordance with standard practices of the Centers for Disease Control and Prevention.

''(c) CONTENT.—The Congenital Heart Disease Surveillance System—

''(1) may include information concerning the incidence and prevalence of congenital heart disease in the United States;

''(2) may be used to collect and store data on congenital heart disease, including data concerning—

''(A) demographic factors associated with congenital heart disease, such as age, race, ethnicity, sex, and family history of individuals who are diagnosed with the disease;

''(B) risk factors associated with the disease;

''(C) causation of the disease;

''(D) treatment approaches; and

''(E) outcome measures, such that analysis of the outcome measures will allow derivation of evidence-based best practices and guidelines for congenital heart disease patients; and

''(3) may ensure the collection and analysis of longitudinal data related to individuals of all ages with congenital heart disease, including infants, young children, adolescents, and adults of all ages.

''(d) PUBLIC ACCESS.—The Congenital Heart Disease Surveillance System shall be made available to the public, as appropriate, including congenital heart disease researchers.

''(e) PATIENT PRIVACY.—The Secretary shall ensure that the Congenital Heart Disease Surveillance System is maintained in a manner that complies with the regulations promulgated under section 264 of the Health Insurance Portability and Accountability Act of 1996.

''(f) ELIGIBILITY FOR GRANT.—To be eligible to receive a grant under subsection (a)(2), an entity shall—

''(1) be a public or private nonprofit entity with specialized experience in congenital heart disease; and

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

(2) CONGENITAL HEART DISEASE RESEARCH.—Subpart 2 of part C of title IV of the Public Health Service Act (42 U.S.C. 285b et seq.) is amended by adding at the end the following:

''SEC. 425. CONGENITAL HEART DISEASE.

''(a) IN GENERAL.—The Director of the Institute may expand, intensify, and coordinate research and related activities of the Institute with respect to congenital heart disease, which may include congenital heart disease research with respect to—

''(1) causation of congenital heart disease, including genetic causes;

''(2) long-term outcomes in individuals with congenital heart disease, including infants, children, teenagers, adults, and elderly individuals;

''(3) diagnosis, treatment, and prevention;

''(4) studies using longitudinal data and retrospective analysis to identify effective treatments and outcomes for individuals with congenital heart disease; and

''(5) identifying barriers to life-long care for individuals with congenital heart disease.

''(b) COORDINATION OF RESEARCH ACTIVITIES.—The Director of the Institute may coordinate research efforts related to congenital heart disease among multiple research institutions and may develop research networks.

''(c) MINORITY AND MEDICALLY UNDERSERVED COMMUNITIES.—In carrying out the activities described in this section, the Director of the Institute shall consider the application of such research and other activities to minority and medically underserved communities.''.

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out the amendments made by this section such sums as may be necessary for each of fiscal years 2011 through 2015.

SEC. 10412. AUTOMATED DEFIBRILLATION IN ADAM'S MEMORY ACT.

Section 312 of the Public Health Service Act (42 U.S.C. 244) is amended—

(1) in subsection (c)(6), after ''clearinghouse'' insert '', that shall be administered by an organization that has substantial expertise in pediatric education, pediatric medicine, and electrophysiology and sudden death,''; and

(2) in the first sentence of subsection (e), by striking ''fiscal year 2003'' and all that follows through ''2006'' and inserting ''for each of fiscal years 2003 through 2014''.

SEC. 10413. YOUNG WOMEN'S BREAST HEALTH AWARENESS AND SUPPORT OF YOUNG WOMEN DIAGNOSED WITH BREAST CANCER.

(a) SHORT TITLE.—This section may be cited as the ''Young Women's Breast Health Education and Awareness Requires Learning Young Act of 2009'' or the ''EARLY Act''.

(b) AMENDMENT.—Title III of the Public Health Service Act (42 U.S.C. 241 et seq.), as amended by this Act, is further amended by adding at the end the following:

''PART V—PROGRAMS RELATING TO BREAST HEALTH AND CANCER

''SEC. 399NN. YOUNG WOMEN'S BREAST HEALTH AWARENESS AND SUPPORT OF YOUNG WOMEN DIAGNOSED WITH BREAST CANCER.

''(a) PUBLIC EDUCATION CAMPAIGN.—

''(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall conduct a national evidence-based education campaign to increase awareness of young women's knowledge regarding—

''(A) breast health in young women of all racial, ethnic, and cultural backgrounds;

''(B) breast awareness and good breast health habits;

''(C) the occurrence of breast cancer and the general and specific risk factors in women who may be at high risk for breast cancer based on familial, racial, ethnic, and cultural backgrounds such as Ashkenazi Jewish populations;

''(D) evidence-based information that would encourage young women and their health care professional to increase early detection of breast cancers; and

''(E) the availability of health information and other resources for young women diagnosed with breast cancer.

''(2) EVIDENCE-BASED, AGE APPROPRIATE MESSAGES.—The campaign shall provide evidence-based, age-appropriate messages and materials as developed by the Centers for Disease Control and Prevention and the Advisory Committee established under paragraph (4).

''(3) MEDIA CAMPAIGN.—In conducting the education campaign under paragraph (1), the Secretary shall award grants to entities to establish national multimedia campaigns oriented to young women that may include advertising through television, radio, print media, billboards, posters, all forms of existing and especially emerging social networking media, other Internet media, and any other medium determined appropriate by the Secretary.

''(4) ADVISORY COMMITTEE.—

''(A) ESTABLISHMENT.—Not later than 60 days after the date of the enactment of this section, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish an advisory committee to assist in creating and conducting the education campaigns under paragraph (1) and subsection (b)(1).

''(B) MEMBERSHIP.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall appoint to the advisory committee under subparagraph (A) such members as deemed necessary to properly advise the Secretary, and shall include organizations and individuals with expertise in breast cancer, disease prevention, early detection, diagnosis, public health, social marketing, genetic screening and counseling, treatment, rehabilitation, palliative care, and survivorship in young women.

''(b) HEALTH CARE PROFESSIONAL EDUCATION CAMPAIGN.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, and in consultation with the Administrator of the Health Resources and Services Administration, shall conduct an education campaign among physicians and other health care professionals to increase awareness—

''(1) of breast health, symptoms, and early diagnosis and treatment of breast cancer in young women, including specific risk factors such as family history of cancer and women that may be at high risk for breast cancer, such as Ashkenazi Jewish population;

''(2) on how to provide counseling to young women about their breast health, including knowledge of their family cancer history and importance of providing regular clinical breast examinations;

''(3) concerning the importance of discussing healthy behaviors, and increasing awareness of services and programs available to address overall health and wellness, and making patient referrals to address tobacco cessation, good nutrition, and physical activity;

''(4) on when to refer patients to a health care provider with genetics expertise;

''(5) on how to provide counseling that addresses long-term survivorship and health concerns of young women diagnosed with breast cancer; and

''(6) on when to provide referrals to organizations and institutions that provide credible health information and substantive assistance and support to young women diagnosed with breast cancer.

''(c) PREVENTION RESEARCH ACTIVITIES.—The Secretary, acting through—

''(1) the Director of the Centers for Disease Control and Prevention, shall conduct prevention research on breast cancer in younger women, including—

''(A) behavioral, survivorship studies, and other research on the impact of breast cancer diagnosis on young women;

''(B) formative research to assist with the development of educational messages and information for the public, targeted populations, and their families about breast health, breast cancer, and healthy lifestyles;

''(C) testing and evaluating existing and new social marketing strategies targeted at young women; and

''(D) surveys of health care providers and the public regarding knowledge, attitudes, and practices related to breast health and breast cancer prevention and control in high-risk populations; and

''(2) the Director of the National Institutes of Health, shall conduct research to develop and validate new screening tests and methods for prevention and early detection of breast cancer in young women.

''(d) SUPPORT FOR YOUNG WOMEN DIAGNOSED WITH BREAST CANCER.—

''(1) IN GENERAL.—The Secretary shall award grants to organizations and institutions to provide health information from credible sources and substantive assistance directed to young women diagnosed with breast cancer and pre-neoplastic breast diseases.

''(2) PRIORITY.—In making grants under paragraph (1), the Secretary shall give priority to applicants that deal specifically with young women diagnosed with breast cancer and pre-neoplastic breast disease.

''(e) NO DUPLICATION OF EFFORT.—In conducting an education campaign or other program under subsections (a), (b), (c), or (d), the Secretary shall avoid duplicating other existing Federal breast cancer education efforts.

''(f) MEASUREMENT; REPORTING.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall—

''(1) measure—

''(A) young women's awareness regarding breast health, including knowledge of family cancer history, specific risk factors and early warning signs, and young women's proactive efforts at early detection;

''(B) the number or percentage of young women utilizing information regarding lifestyle interventions that foster healthy behaviors;

''(C) the number or percentage of young women receiving regular clinical breast exams; and

''(D) the number or percentage of young women who perform breast self exams, and the frequency of such exams, before the implementation of this section;

''(2) not less than every 3 years, measure the impact of such activities; and

''(3) submit reports to the Congress on the results of such measurements.

''(g) DEFINITION.—In this section, the term 'young women' means women 15 to 44 years of age.

''(h) AUTHORIZATION OF APPROPRIATIONS.—To carry out subsections (a), (b), (c)(1), and (d), there are authorized to be appropriated $9,000,000 for each of the fiscal years 2010 through 2014.''.

Subtitle E—Provisions Relating to Title V

SEC. 10501. AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT, THE SOCIAL SECURITY ACT, AND TITLE V OF THIS ACT.

(a) Section 5101 of this Act is amended—

(1) in subsection (c)(2)(B)(i)(II), by inserting '', including representatives of small business and self-employed individuals'' after ''employers'';

(2) in subsection (d)(4)(A)—

(A) by redesignating clause (iv) as clause (v); and

(B) by inserting after clause (iii) the following:

''(iv) An analysis of, and recommendations for, eliminating the barriers to entering and staying in primary care, including provider compensation.''; and

(3) in subsection (i)(2)(B), by inserting ''optometrists, ophthalmologists,'' after ''occupational therapists,''.

(b) Subtitle B of title V of this Act is amended by adding at the end the following:

''SEC. 5104. INTERAGENCY TASK FORCE TO ASSESS AND IMPROVE ACCESS TO HEALTH CARE IN THE STATE OF ALASKA.

''(a) ESTABLISHMENT.—There is established a task force to be known as the 'Interagency Access to Health Care in Alaska Task Force' (referred to in this section as the 'Task Force').

''(b) DUTIES.—The Task Force shall—

''(1) assess access to health care for beneficiaries of Federal health care systems in Alaska; and

''(2) develop a strategy for the Federal Government to improve delivery of health care to Federal beneficiaries in the State of Alaska.

''(c) MEMBERSHIP.—The Task Force shall be comprised of Federal members who shall be appointed, not later than 45 days after the date of enactment of this Act, as follows:

''(1) The Secretary of Health and Human Services shall appoint one representative of each of the following:

''(A) The Department of Health and Human Services.

''(B) The Centers for Medicare and Medicaid Services.

''(C) The Indian Health Service.

''(2) The Secretary of Defense shall appoint one representative of the TRICARE Management Activity.

''(3) The Secretary of the Army shall appoint one representative of the Army Medical Department.

''(4) The Secretary of the Air Force shall appoint one representative of the Air Force, from among officers at the Air Force performing medical service functions.

''(5) The Secretary of Veterans Affairs shall appoint one representative of each of the following:

''(A) The Department of Veterans Affairs.

''(B) The Veterans Health Administration.

''(6) The Secretary of Homeland Security shall appoint one representative of the United States Coast Guard.

''(d) CHAIRPERSON.—One chairperson of the Task Force shall be appointed by the Secretary at the time of appointment of members under subsection (c), selected from among the members appointed under paragraph (1).

''(e) MEETINGS.—The Task Force shall meet at the call of the chairperson.

''(f) REPORT.—Not later than 180 days after the date of enactment of this Act, the Task Force shall submit to Congress a report detailing the activities of the Task Force and containing the findings, strategies, recommendations, policies, and initiatives developed pursuant to the duty described in subsection (b)(2). In preparing such report, the Task Force shall consider completed and ongoing efforts by Federal agencies to improve access to health care in the State of Alaska.

''(g) TERMINATION.—The Task Force shall be terminated on the date of submission of the report described in subsection (f).''.

(c) Section 399V of the Public Health Service Act, as added by section 5313, is amended—

(1) in subsection (b)(4), by striking ''identify, educate, refer, and enroll'' and inserting ''identify and refer''; and

(2) in subsection (k)(1), by striking '', as defined by the Department of Labor as Standard Occupational Classification [21–1094]''.

(d) Section 738(a)(3) of the Public Health Service Act (42 U.S.C. 293b(a)(3)) is amended by inserting ''schools offering physician assistant education programs,'' after ''public health,''.

(e) Subtitle D of title V of this Act is amended by adding at the end the following:

"SEC. 5316. DEMONSTRATION GRANTS FOR FAMILY NURSE PRACTITIONER TRAINING PROGRAMS.

''(a) ESTABLISHMENT OF PROGRAM.—The Secretary of Health and Human Services (referred to in this section as the 'Secretary') shall establish a training demonstration program for family nurse practitioners (referred to in this section as the 'program') to employ and provide 1-year training for nurse practitioners who have graduated from a nurse practitioner program for careers as primary care providers in Federally qualified health centers (referred to in this section as 'FQHCs') and nurse-managed health clinics (referred to in this section as 'NMHCs').

''(b) PURPOSE.—The purpose of the program is to enable each grant recipient to—

''(1) provide new nurse practitioners with clinical training to enable them to serve as primary care providers in FQHCs and NMHCs;

''(2) train new nurse practitioners to work under a model of primary care that is consistent with the principles set forth by the Institute of Medicine and the needs of vulnerable populations; and

''(3) create a model of FQHC and NMHC training for nurse practitioners that may be replicated nationwide.

''(c) GRANTS.—The Secretary shall award 3-year grants to eligible entities that meet the requirements established by the Secretary, for the purpose of operating the nurse practitioner primary care programs described in subsection (a) in such entities.

''(d) ELIGIBLE ENTITIES.—To be eligible to receive a grant under this section, an entity shall—

''(1)(A) be a FQHC as defined in section 1861(aa) of the Social Security Act (42 U.S.C. 1395x(aa)); or

''(B) be a nurse-managed health clinic, as defined in section 330A-1 of the Public Health Service Act (as added by section 5208 of this Act); and

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

''(e) PRIORITY IN AWARDING GRANTS.—In awarding grants under this section, the Secretary shall give priority to eligible entities that—

''(1) demonstrate sufficient infrastructure in size, scope, and capacity to undertake the requisite training of a minimum of 3 nurse practitioners per year, and to provide to each awardee 12 full months of full-time, paid employment and benefits consistent with the benefits offered to other full-time employees of such entity;

''(2) will assign not less than 1 staff nurse practitioner or physician to each of 4 precepted clinics;

''(3) will provide to each awardee specialty rotations, including specialty training in prenatal care and women's health, adult and child psychiatry, orthopedics, geriatrics, and at least 3 other high-volume, high-burden specialty areas;

''(4) provide sessions on high-volume, high-risk health problems and have a record of training health care professionals in the care of children, older adults, and underserved populations; and

''(5) collaborate with other safety net providers, schools, colleges, and universities that provide health professions training.

''(f) ELIGIBILITY OF NURSE PRACTITIONERS.—

''(1) IN GENERAL.—To be eligible for acceptance to a program funded through a grant awarded under this section, an individual shall—

''(A) be licensed or eligible for licensure in the State in which the program is located as an advanced practice registered nurse or advanced practice nurse and be eligible or board-certified as a family nurse practitioner; and

''(B) demonstrate commitment to a career as a primary care provider in a FQHC or in a NMHC.

''(2) PREFERENCE.—In selecting awardees under the program, each grant recipient shall give preference to bilingual candidates that meet the requirements described in paragraph (1).

''(3) DEFERRAL OF CERTAIN SERVICE.—The starting date of required service of individuals in the National Health Service Corps Service program under title II of the Public Health Service Act (42 U.S.C. 202 et seq.) who receive training under this section shall be deferred until the date that is 22 days after the date of completion of the program.

''(g) GRANT AMOUNT.—Each grant awarded under this section shall be in an amount not to exceed $600,000 per year. A grant recipient may carry over funds from 1 fiscal year to another without obtaining approval from the Secretary.

''(h) TECHNICAL ASSISTANCE GRANTS.—The Secretary may award technical assistance grants to 1 or more FQHCs or NMHCs that have demonstrated expertise in establishing a nurse practitioner residency training program. Such technical assistance grants shall be for the purpose of providing technical assistance to other recipients of grants under subsection (c).

''(i) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated such sums as may be necessary for each of fiscal years 2011 through 2014.''.

(f)(1) Section 399W of the Public Health Service Act, as added by section 5405, is redesignated as section 399V–1.

(2) Section 399V–1 of the Public Health Service Act, as so redesignated, is amended in subsection (b)(2)(A) by striking ''and the departments of 1 or more health professions schools in the State that train providers in primary care'' and inserting ''and the departments that train providers in primary care in 1 or more health professions schools in the State''.

(3) Section 934 of the Public Health Service Act, as added by section 3501, is amended by striking ''399W'' each place such term appears and inserting ''399V–1''.

(4) Section 935(b) of the Public Health Service Act, as added by section 3503, is amended by striking ''399W'' and inserting ''399V–1''.

(g) Part P of title III of the Public Health Service Act 42 U.S.C. 280g et seq.), as amended by section 10411, is amended by adding at the end the following:

"SEC. 399V-3. NATIONAL DIABETES PREVENTION PROGRAM.

''(a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish a national diabetes prevention program (referred to in this section as the 'program') targeted at adults at high risk for diabetes in order to eliminate the preventable burden of diabetes.

''(b) PROGRAM ACTIVITIES.—The program described in subsection (a) shall include—

''(1) a grant program for community-based diabetes prevention program model sites;

''(2) a program within the Centers for Disease Control and Prevention to determine eligibility of entities to deliver community-based diabetes prevention services;

''(3) a training and outreach program for lifestyle intervention instructors; and

''(4) evaluation, monitoring and technical assistance, and applied research carried out by the Centers for Disease Control and Prevention.

''(c) ELIGIBLE ENTITIES.—To be eligible for a grant under subsection (b)(1), an entity shall be a State or local health department, a tribal organization, a national network of community-based non-profits focused on health and wellbeing, an academic institution, or other entity, as the Secretary determines.

''(d) 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) The provisions of, and amendment made by, section 5501(c) of this Act are repealed.

(i)(1) The provisions of, and amendments made by, section 5502 of this Act are repealed.

(2)(A) 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 in subparagraphs (A) through (C) of paragraph (1) and preventive services (as defined in section 1861(ddd)(3)); and''.

(B) The amendment made by subparagraph (A) shall apply to services furnished on or after January 1, 2011.

(3)(A) Section 1834 of the Social Security Act (42 U.S.C. 1395m), as amended by section 4105, is amended by adding at the end the following new subsection:

''(o) 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 center 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 and shall establish payment rates for specific payment codes based on such appropriate descriptions of services. Such system shall be established to take into account the type, intensity, and duration of services furnished by Federally qualified health centers. Such system may include adjustments, including geographic adjustments, determined appropriate by the Secretary.

''(B) COLLECTION OF DATA AND EVALUATION.—By not later than January 1, 2011, 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 subsection, including the reporting of services using HCPCS codes.

''(2) IMPLEMENTATION.—

''(A) IN GENERAL.—Notwithstanding section 1833(a)(3)(A), the Secretary shall provide, for cost reporting periods beginning on or after October 1, 2014, for payments of prospective payment rates for Federally qualified health center 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 aggregate amount of prospective payment rates (determined prior to the application of section 1833(a)(1)(Z)) under this title for Federally qualified health center services in the first year that such system is implemented is equal to 100 percent of the estimated amount of reasonable costs (determined without the application of a per visit payment limit or productivity screen and prior to the application of section 1866(a)(2)(A)(ii)) that would have occurred for such services under this title in such year if the system had not been implemented.

''(ii) PAYMENTS IN SUBSEQUENT YEARS.—Payment rates in years after the year of implementation of such system shall be the payment rates in the previous year increased—

''(I) in the first year after implementation of such system, by the percentage increase in the MEI (as defined in section 1842(i)(3)) for the year involved; and

''(II) in subsequent years, by the percentage increase in a market basket of Federally qualified health center goods and services as promulgated through regulations, or if such an index is not available, by the percentage increase in the MEI (as defined in section 1842(i)(3)) for the year involved.

''(C) PREPARATION FOR PPS IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary may establish and implement by program instruction or otherwise the payment codes to be used under the prospective payment system under this section.''.

(B) Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)), as amended by section 4104, is amended—

(i) by striking ''and'' before ''(Y)''; and

(ii) by inserting before the semicolon at the end the following: '', and (Z) with respect to Federally qualified health center services for which payment is made under section 1834(o), the amounts paid shall be 80 percent of the lesser of the actual charge or the amount determined under such section''.

(C) Section 1833(a) of the Social Security Act (42 U.S.C. 1395l(a)) is amended—

(i) in paragraph (3)(B)(i)—

(I) by inserting ''(I)'' after ''otherwise been provided''; and

(II) by inserting '', or (II) in the case of such services furnished on or after the implementation date of the prospective payment system under section 1834(o), under such section (calculated as if '100 percent' were substituted for '80 percent' in such section) for such services if the individual had not been so enrolled'' after ''been so enrolled''; and

(ii) by adding at the end the following flush sentence:

''Paragraph (3)(A) shall not apply to Federally qualified health center services furnished on or after the implementation date of the prospective payment system under section 1834(0).''.

(j) Section 5505 is amended by adding at the end the following new subsection:

''(d) APPLICATION.—The amendments made by this section shall not be applied in a manner that requires reopening of any settled 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)).''.

(k) Subtitle G of title V of this Act is amended by adding at the end the following:

''SEC. 5606. STATE GRANTS TO HEALTH CARE PROVIDERS WHO PROVIDE SERVICES TO A HIGH PERCENTAGE OF MEDICALLY UNDERSERVED POPULATIONS OR OTHER SPECIAL POPULATIONS.

''(a) IN GENERAL.—A State may award grants to health care providers who treat a high percentage, as determined by such State, of medically underserved populations or other special populations in such State.

''(b) SOURCE OF FUNDS.—A grant program established by a State under subsection (a) may not be established within a department, agency, or other entity of such State that administers the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), and no Federal or State funds allocated to such Medicaid program, the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), or the TRICARE program under chapter 55 of title 10, United States Code, may be used to award grants or to pay administrative costs associated with a grant program established under subsection (a).''.

(l) Part C of title VII of the Public Health Service Act (42 U.S.C. 293k et seq.) is amended—

(1) after the part heading, by inserting the following:

''Subpart I—Medical Training Generally'';

and

(2) by inserting at the end the following:

''Subpart II—Training in Underserved Communities

''SEC. 749B. RURAL PHYSICIAN TRAINING GRANTS.

''(a) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall establish a grant program for the purposes of assisting eligible entities in recruiting students most likely to practice medicine in underserved rural communities, providing rural-focused training and experience, and increasing the number of recent allopathic and osteopathic medical school graduates who practice in underserved rural communities.

''(b) ELIGIBLE ENTITIES.—In order to be eligible to receive a grant under this section, an entity shall—

''(1) be a school of allopathic or osteopathic medicine accredited by a nationally recognized accrediting agency or association approved by the Secretary for this purpose, or any combination or consortium of such schools; and

''(2) submit an application to the Secretary that includes a certification that such entity will use amounts provided to the institution as described in subsection (d)(1).

''(c) PRIORITY.—In awarding grant funds under this section, the Secretary shall give priority to eligible entities that—

''(1) demonstrate a record of successfully training students, as determined by the Secretary, who practice medicine in underserved rural communities;

''(2) demonstrate that an existing academic program of the eligible entity produces a high percentage, as determined by the Secretary, of graduates from such program who practice medicine in underserved rural communities;

''(3) demonstrate rural community institutional partnerships, through such mechanisms as matching or contributory funding, documented in-kind services for implementation, or existence of training partners with interprofessional expertise in community health center training locations or other similar facilities; or

''(4) submit, as part of the application of the entity under subsection (b), a plan for the long-term tracking of where the graduates of such entity practice medicine.

''(d) USE OF FUNDS.—

''(1) ESTABLISHMENT.—An eligible entity receiving a grant under this section shall use the funds made available under such grant to establish, improve, or expand a rural-focused training program (referred to in this section as the 'Program') meeting the requirements described in this subsection and to carry out such program.

''(2) STRUCTURE OF PROGRAM.—An eligible entity shall—

''(A) enroll no fewer than 10 students per class year into the Program; and

''(B) develop criteria for admission to the Program that gives priority to students—

''(i) who have originated from or lived for a period of 2 or more years in an underserved rural community; and

''(ii) who express a commitment to practice medicine in an underserved rural community.

''(3) CURRICULA.—The Program shall require students to enroll in didactic coursework and clinical experience particularly applicable to medical practice in underserved rural communities, including—

''(A) clinical rotations in underserved rural communities, and in applicable specialties, or other coursework or clinical experience deemed appropriate by the Secretary; and

''(B) in addition to core school curricula, additional coursework or training experiences focused on medical issues prevalent in underserved rural communities.

''(4) RESIDENCY PLACEMENT ASSISTANCE.—Where available, the Program shall assist all students of the Program in obtaining clinical training experiences in locations with postgraduate programs offering residency training opportunities in underserved rural communities, or in local residency training programs that support and train physicians to practice in underserved rural communities.

''(5) PROGRAM STUDENT COHORT SUPPORT.—The Program shall provide and require all students of the Program to participate in group activities designed to further develop, maintain, and reinforce the original commitment of such students to practice in an underserved rural community.

''(e) ANNUAL REPORTING.—An eligible entity receiving a grant under this section shall submit an annual report to the Secretary on the success of the Program, based on criteria the Secretary determines appropriate, including the residency program selection of graduating students who participated in the Program.

''(f) REGULATIONS.—Not later than 60 days after the date of enactment of this section, the Secretary shall by regulation define 'underserved rural community' for purposes of this section.

''(g) SUPPLEMENT NOT SUPPLANT.—Any eligible entity receiving funds under this section shall use such funds to supplement, not supplant, any other Federal, State, and local funds that would otherwise be expended by such entity to carry out the activities described in this section.

''(h) MAINTENANCE OF EFFORT.—With respect to activities for which funds awarded under this section are to be expended, the entity shall agree to maintain expenditures of non-Federal amounts for such activities at a level that is not less than the level of such expenditures maintained by the entity for the fiscal year preceding the fiscal year for which the entity receives a grant under this section.

''(i) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $4,000,000 for each of the fiscal years 2010 through 2013.''.

(m)(1) Section 768 of the Public Health Service Act (42 U.S.C. 295c) is amended to read as follows:

''SEC. 768. PREVENTIVE MEDICINE AND PUBLIC HEALTH TRAINING GRANT PROGRAM.

''(a) GRANTS.—The Secretary, acting through the Administrator of the Health Resources and Services Administration and in consultation with the Director of the Centers for Disease Control and Prevention, shall award grants to, or enter into contracts with, eligible entities to provide training to graduate medical residents in preventive medicine specialties.

''(b) ELIGIBILITY.—To be eligible for a grant or contract under subsection (a), an entity shall be—

''(1) an accredited school of public health or school of medicine or osteopathic medicine;

''(2) an accredited public or private nonprofit hospital;

''(3) a State, local, or tribal health department; or

''(4) a consortium of 2 or more entities described in paragraphs (1) through (3).

''(c) USE OF FUNDS.—Amounts received under a grant or contract under this section shall be used to—

''(1) plan, develop (including the development of curricula), operate, or participate in an accredited residency or internship program in preventive medicine or public health;

''(2) defray the costs of practicum experiences, as required in such a program; and

''(3) establish, maintain, or improve—

''(A) academic administrative units (including departments, divisions, or other appropriate units) in preventive medicine and public health; or

''(B) programs that improve clinical teaching in preventive medicine and public health.

''(d) REPORT.—The Secretary shall submit to the Congress an annual report on the program carried out under this section.''.

(2) Section 770(a) of the Public Health Service Act (42 U.S.C. 295e(a)) is amended to read as follows:

''(a) IN GENERAL.—For the purpose of carrying out this subpart, there is authorized to be appropriated $43,000,000 for fiscal year 2011, and such sums as may be necessary for each of the fiscal years 2012 through 2015.''.

(n)(1) Subsection (i) of section 331 of the Public Health Service Act (42 U.S.C. 254d) of the Public Health Service Act is amended—

(A) in paragraph (1), by striking ''In carrying out subpart III'' and all that follows through the period and inserting ''In carrying out subpart III, the Secretary may, in accordance with this subsection, issue waivers to individuals who have entered into a contract for obligated service under the Scholarship Program or the Loan Repayment Program under which the individuals are authorized to satisfy the requirement of obligated service through providing clinical practice that is half time.'';

(B) in paragraph (2)—

(i) in subparagraphs (A)(ii) and (B), by striking ''less than full time'' each place it appears and inserting ''half time'';

(ii) in subparagraphs (C) and (F), by striking ''less than full-time service'' each place it appears and inserting ''half-time service''; and

(iii) by amending subparagraphs (D) and (E) to read as follows:

''(D) the entity and the Corps member agree in writing that the Corps member will perform half-time clinical practice;

''(E) the Corps member agrees in writing to fulfill all of the service obligations under section 338C through half-time clinical practice and either—

''(i) double the period of obligated service that would otherwise be required; or

''(ii) in the case of contracts entered into under section 338B, accept a minimum service obligation of 2 years with an award amount equal to 50 percent of the amount that would otherwise be payable for full-time service; and''; and

(C) in paragraph (3), by striking ''In evaluating a demonstration project described in paragraph (1)'' and inserting ''In evaluating waivers issued under paragraph (1)''.

(2) Subsection (j) of section 331 of the Public Health Service Act (42 U.S.C. 254d) is amended by adding at the end the following:

''(5) The terms 'full time' and 'full-time' mean a minimum of 40 hours per week in a clinical practice, for a minimum of 45 weeks per year.

''(6) The terms 'half time' and 'half-time' mean a minimum of 20 hours per week (not to exceed 39 hours per week) in a clinical practice, for a minimum of 45 weeks per year.''.

(3) Section 337(b)(1) of the Public Health Service Act (42 U.S.C. 254j(b)(1)) is amended by striking ''Members may not be reappointed to the Council.''.

(4) Section 338B(g)(2)(A) of the Public Health Service Act (42 U.S.C. 254l–1(g)(2)(A)) is amended by striking ''$35,000'' and inserting ''$50,000, plus, beginning with fiscal year 2012, an amount determined by the Secretary on an annual basis to reflect inflation,''.

(5) Subsection (a) of section 338C of the Public Health Service Act (42 U.S.C. 254m), as amended by section 5508, is amended—

(A) by striking the second sentence and inserting the following: ''The Secretary may treat teaching as clinical practice for up to 20 percent of such period of obligated service.''; and

(B) by adding at the end the following: ''Notwithstanding the preceding sentence, with respect to a member of the Corps participating in the teaching health centers graduate medical education program under section 340H, for the purpose of calculating time spent in full-time clinical practice under this section, up to 50 percent of time spent teaching by such member may be counted toward his or her service obligation.''.

SEC. 10502. INFRASTRUCTURE TO EXPAND ACCESS TO CARE.

(a) APPROPRIATION.—There are authorized to be appropriated, and there are appropriated to the Department of Health and Human Services, $100,000,000 for fiscal year 2010, to remain available for obligation until September 30, 2011, to be used for debt service on, or direct construction or renovation of, a health care facility that provides research, inpatient tertiary care, or outpatient clinical services. Such facility shall be affiliated with an academic health center at a public research university in the United States that contains a State's sole public academic medical and dental school.

(b) REQUIREMENT.—Amount appropriated under subsection (a) may only be made available by the Secretary of Health and Human Services upon the receipt of an application from the Governor of a State that certifies that—

(1) the new health care facility is critical for the provision of greater access to health care within the State;

(2) such facility is essential for the continued financial viability of the State's sole public medical and dental school and its academic health center;

(3) the request for Federal support represents not more than 40 percent of the total cost of the proposed new facility; and

(4) the State has established a dedicated funding mechanism to provide all remaining funds necessary to complete the construction or renovation of the proposed facility.

SEC. 10503. COMMUNITY HEALTH CENTERS AND THE NATIONAL HEALTH SERVICE CORPS FUND.

(a) PURPOSE.—It is the purpose of this section to establish a Community Health Center Fund (referred to in this section as the ''CHC Fund''), to be administered through the Office of the Secretary of the Department of Health and Human Services to provide for expanded and sustained national investment in community health centers under section 330 of the Public Health Service Act and the National Health Service Corps.

(b) FUNDING.—There is authorized to be appropriated, and there is appropriated, out of any monies in the Treasury not otherwise appropriated, to the CHC Fund—

(1) to be transferred to the Secretary of Health and Human Services to provide enhanced funding for the community health center program under section 330 of the Public Health Service Act—

(A) $700,000,000 for fiscal year 2011;

(B) $800,000,000 for fiscal year 2012;

(C) $1,000,000,000 for fiscal year 2013;

(D) $1,600,000,000 for fiscal year 2014; and

(E) $2,900,000,000 for fiscal year 2015; and

(2) to be transferred to the Secretary of Health and Human Services to provide enhanced funding for the National Health Service Corps—

(A) $290,000,000 for fiscal year 2011;

(B) $295,000,000 for fiscal year 2012;

(C) $300,000,000 for fiscal year 2013;

(D) $305,000,000 for fiscal year 2014; and

(E) $310,000,000 for fiscal year 2015.

(c) CONSTRUCTION.—There is authorized to be appropriated, and there is appropriated, out of any monies in the Treasury not otherwise appropriated, $1,500,000,000 to be available for fiscal years 2011 through 2015 to be used by the Secretary of Health and Human Services for the construction and renovation of community health centers.

(d) USE OF FUND.—The Secretary of Health and Human Services shall transfer amounts in the CHC Fund to accounts within the Department of Health and Human Services to increase funding, over the fiscal year 2008 level, for community health centers and the National Health Service Corps.

(e) AVAILABILITY.—Amounts appropriated under subsections (b) and (c) shall remain available until expended.

SEC. 10504. DEMONSTRATION PROJECT TO PROVIDE ACCESS TO AFFORDABLE CARE.

(a) IN GENERAL.—Not later than 6 months after the date of enactment of this Act, the Secretary of Health and Human Services (referred to in this section as the ''Secretary''), acting through the Health Resources and Services Administration, shall establish a 3 year demonstration project in up to 10 States to provide access to comprehensive health care services to the uninsured at reduced fees. The Secretary shall evaluate the feasibility of expanding the project to additional States.

(b) ELIGIBILITY.—To be eligible to participate in the demonstration project, an entity shall be a State-based, nonprofit, public-private partnership that provides access to comprehensive health care services to the uninsured at reduced fees. Each State in which a participant selected by the Secretary is located shall receive not more than $2,000,000 to establish and carry out the project for the 3-year demonstration period.

(c) AUTHORIZATION.—There is authorized to be appropriated such sums as may be necessary to carry out this section.

Subtitle F—Provisions Relating to Title VI

SEC. 10601. REVISIONS TO LIMITATION ON MEDICARE EXCEPTION TO THE PROHIBITION ON CERTAIN PHYSICIAN REFERRALS FOR HOSPITALS.

(a) IN GENERAL.—Section 1877(i) of the Social Security Act, as added by section 6001(a), is amended—

(1) in paragraph (1)(A)(i), by striking ''February 1, 2010'' and inserting ''August 1, 2010''; and

(2) in paragraph (3)(A)—

(A) in clause (iii), by striking ''August 1, 2011'' and inserting ''February 1, 2012''; and

(B) in clause (iv), by striking ''July 1, 2011'' and inserting ''January 1, 2012''.

(b) CONFORMING AMENDMENT.—Section 6001(b)(2) of this Act is amended by striking ''November 1, 2011'' and inserting ''May 1, 2012''.

SEC. 10602. CLARIFICATIONS TO PATIENT-CENTERED OUTCOMES RESEARCH.

Section 1181 of the Social Security Act (as added by section 6301) is amended—

(1) in subsection (d)(2)(B)—

(A) in clause (ii)(IV)—

(i) by inserting '', as described in subparagraph (A)(ii),'' after ''original research''; and

(ii) by inserting '', as long as the researcher enters into a data use agreement with the Institute for use of the data from the original research, as appropriate'' after ''publication''; and

(B) by amending clause (iv) to read as follows:

''(iv) SUBSEQUENT USE OF THE DATA.—The Institute shall not allow the subsequent use of data from original research in work-for-hire contracts with individuals, entities, or instrumentalities that have a financial interest in the results, unless approved under a data use agreement with the Institute.'';

(2) in subsection (d)(8)(A)(iv), by striking ''not be construed as mandates for'' and inserting ''do not include''; and

(3) in subsection (f)(1)(C), by amending clause (ii) to read as follows:

''(ii) 7 members representing physicians and providers, including 4 members representing physicians (at least 1 of whom is a surgeon), 1 nurse, 1 State-licensed integrative health care practitioner, and 1 representative of a hospital.''.

SEC. 10603. STRIKING PROVISIONS RELATING TO INDIVIDUAL PROVIDER APPLICATION FEES.

(a) IN GENERAL.—Section 1866(j)(2)(C) of the Social Security Act, as added by section 6401(a), is amended—

(1) by striking clause (i);

(2) by redesignating clauses (ii) through (iv), respectively, as clauses (i) through (iii); and

(3) in clause (i), as redesignated by paragraph (2), by striking ''clause (iii)'' and inserting ''clause (ii)''.

(b) TECHNICAL CORRECTION.—Section 6401(a)(2) of this Act is amended to read as follows:

''(2) by redesignating paragraph (2) as paragraph (8); and''.

SEC. 10604. TECHNICAL CORRECTION TO SECTION 6405.

Paragraphs (1) and (2) of section 6405(b) are amended to read as follows:

''(1) PART A.—Section 1814(a)(2) of the Social Security Act (42 U.S.C. 1395(a)(2)) is amended in the matter preceding subparagraph (A) by inserting ', or, in the case of services described in subparagraph (C), a physician enrolled under section 1866(j),' after 'in collaboration with a physician,'.

''(2) PART B.—Section 1835(a)(2) of the Social Security 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),' after 'a physician'.''.

SEC. 10605. CERTAIN OTHER PROVIDERS PERMITTED TO CONDUCT FACE TO FACE ENCOUNTER FOR HOME HEALTH SERVICES.

(a) PART A.—Section 1814(a)(2)(C) of the Social Security Act (42 U.S.C. 1395f(a)(2)(C)), as amended by section 6407(a)(1), is amended by inserting '', or a nurse practitioner or clinical nurse specialist (as those terms are defined in section 1861(aa)(5)) who is working in collaboration with the physician in accordance with State law, or a certified nurse-midwife (as defined in section 1861(gg)) as authorized by State law, or a physician assistant (as defined in section 1861(aa)(5)) under the supervision of the physician,'' after ''himself or herself''.

(b) PART B.—Section 1835(a)(2)(A)(iv) of the Social Security Act, as added by section 6407(a)(2), is amended by inserting '', or a nurse practitioner or clinical nurse specialist (as those terms are defined in section 1861(aa)(5)) who is working in collaboration with the physician in accordance with State law, or a certified nurse-midwife (as defined in section 1861(gg)) as authorized by State law, or a physician assistant (as defined in section 1861(aa)(5)) under the supervision of the physician,'' after ''must document that the physician''.

SEC. 10606. HEALTH CARE FRAUD ENFORCEMENT.

(a) FRAUD SENTENCING GUIDELINES.—

(1) DEFINITION.—In this subsection, the term ''Federal health care offense'' has the meaning given that term in section 24 of title 18, United States Code, as amended by this Act.

(2) REVIEW AND AMENDMENTS.—Pursuant to the authority under section 994 of title 28, United States Code, and in accordance with this subsection, the United States Sentencing Commission shall—

(A) review the Federal Sentencing Guidelines and policy statements applicable to persons convicted of Federal health care offenses;

(B) amend the Federal Sentencing Guidelines and policy statements applicable to persons convicted of Federal health care offenses involving Government health care programs to provide that the aggregate dollar amount of fraudulent bills submitted to the Government health care program shall constitute prima facie evidence of the amount of the intended loss by the defendant; and

(C) amend the Federal Sentencing Guidelines to provide—

(i) a 2-level increase in the offense level for any defendant convicted of a Federal health care offense relating to a Government health care program which involves a loss of not less than $1,000,000 and less than $7,000,000;

(ii) a 3-level increase in the offense level for any defendant convicted of a Federal health care offense relating to a Government health care program which involves a loss of not less than $7,000,000 and less than $20,000,000;

(iii) a 4-level increase in the offense level for any defendant convicted of a Federal health care offense relating to a Government health care program which involves a loss of not less than $20,000,000; and

(iv) if appropriate, otherwise amend the Federal Sentencing Guidelines and policy statements applicable to persons convicted of Federal health care offenses involving Government health care programs.

(3) REQUIREMENTS.—In carrying this subsection, the United States Sentencing Commission shall—

(A) ensure that the Federal Sentencing Guidelines and policy statements—

(i) reflect the serious harms associated with health care fraud and the need for aggressive and appropriate law enforcement action to prevent such fraud; and

(ii) provide increased penalties for persons convicted of health care fraud offenses in appropriate circumstances;

(B) consult with individuals or groups representing health care fraud victims, law enforcement officials, the health care industry, and the Federal judiciary as part of the review described in paragraph (2);

(C) ensure reasonable consistency with other relevant directives and with other guidelines under the Federal Sentencing Guidelines;

(D) account for any aggravating or mitigating circumstances that might justify exceptions, including circumstances for which the Federal Sentencing Guidelines, as in effect on the date of enactment of this Act, provide sentencing enhancements;

(E) make any necessary conforming changes to the Federal Sentencing Guidelines; and

(F) ensure that the Federal Sentencing Guidelines adequately meet the purposes of sentencing.

(b) INTENT REQUIREMENT FOR HEALTH CARE FRAUD.—Section 1347 of title 18, United States Code, is amended—

(1) by inserting ''(a)'' before ''Whoever knowingly''; and

(2) by adding at the end the following:

''(b) With respect to violations of this section, a person need not have actual knowledge of this section or specific intent to commit a violation of this section.''.

(c) HEALTH CARE FRAUD OFFENSE.—Section 24(a) of title 18, United States Code, is amended—

(1) in paragraph (1), by striking the semicolon and inserting ''or section 1128B of the Social Security Act (42 U.S.C. 1320a–7b); or''; and

(2) in paragraph (2)—

(A) by inserting ''1349,'' after ''1343,''; and

(B) by inserting ''section 301 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 331), or section 501 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131),'' after ''title,''.

(d) SUBPOENA AUTHORITY RELATING TO HEALTH CARE.—

(1) SUBPOENAS UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996.—Section 1510(b) of title 18, United States Code, is amended—

(A) in paragraph (1), by striking ''to the grand jury''; and

(B) in paragraph (2)—

(i) in subparagraph (A), by striking ''grand jury subpoena'' and inserting ''subpoena for records''; and

(ii) in the matter following subparagraph (B), by striking ''to the grand jury''.

(2) SUBPOENAS UNDER THE CIVIL RIGHTS OF INSTITUTIONALIZED PERSONS ACT.—The Civil Rights of Institutionalized Persons Act (42 U.S.C. 1997 et seq.) is amended by inserting after section 3 the following:

''SEC. 3A. SUBPOENA AUTHORITY.

''(a) AUTHORITY.—The Attorney General, or at the direction of the Attorney General, any officer or employee of the Department of Justice may require by subpoena access to any institution that is the subject of an investigation under this Act and to any document, record, material, file, report, memorandum, policy, procedure, investigation, video or audio recording, or quality assurance report relating to any institution that is the subject of an investigation under this Act to determine whether there are conditions which deprive persons residing in or confined to the institution of any rights, privileges, or immunities secured or protected by the Constitution or laws of the United States.

''(b) ISSUANCE AND ENFORCEMENT OF SUBPOENAS.—

''(1) ISSUANCE.—Subpoenas issued under this section—

''(A) shall bear the signature of the Attorney General or any officer or employee of the Department of Justice as designated by the Attorney General; and

''(B) shall be served by any person or class of persons designated by the Attorney General or a designated officer or employee for that purpose.

''(2) ENFORCEMENT.—In the case of contumacy or failure to obey a subpoena issued under this section, the United States district court for the judicial district in which the institution is located may issue an order requiring compliance. Any failure to obey the order of the court may be punished by the court as a contempt that court.

''(c) PROTECTION OF SUBPOENAED RECORDS AND INFORMATION.—Any document, record, material, file, report, memorandum, policy, procedure, investigation, video or audio recording, or quality assurance report or other information obtained under a subpoena issued under this section—

''(1) may not be used for any purpose other than to protect the rights, privileges, or immunities secured or protected by the Constitution or laws of the United States of persons who reside, have resided, or will reside in an institution;

''(2) may not be transmitted by or within the Department of Justice for any purpose other than to protect the rights, privileges, or immunities secured or protected by the Constitution or laws of the United States of persons who reside, have resided, or will reside in an institution; and

''(3) shall be redacted, obscured, or otherwise altered if used in any publicly available manner so as to prevent the disclosure of any personally identifiable information.''.

SEC. 10607. STATE DEMONSTRATION PROGRAMS TO EVALUATE ALTERNATIVES TO CURRENT MEDICAL TORT LITIGATION.

Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.), as amended by this Act, is further amended by adding at the end the following:

''SEC. 399V–4. STATE DEMONSTRATION PROGRAMS TO EVALUATE ALTERNATIVES TO CURRENT MEDICAL TORT LITIGATION.

''(a) IN GENERAL.—The Secretary is authorized to award demonstration grants to States for the development, implementation, and evaluation of alternatives to current tort litigation for resolving disputes over injuries allegedly caused by health care providers or health care organizations. In awarding such grants, the Secretary shall ensure the diversity of the alternatives so funded.

''(b) DURATION.—The Secretary may award grants under subsection (a) for a period not to exceed 5 years.

''(c) CONDITIONS FOR DEMONSTRATION GRANTS.—

''(1) REQUIREMENTS.—Each State desiring a grant under subsection (a) shall develop an alternative to current tort litigation that—

''(A) allows for the resolution of disputes over injuries allegedly caused by health care providers or health care organizations; and

''(B) promotes a reduction of health care errors by encouraging the collection and analysis of patient safety data related to disputes resolved under subparagraph (A) by organizations that engage in efforts to improve patient safety and the quality of health care.

''(2) ALTERNATIVE TO CURRENT TORT LITIGATION.—Each State desiring a grant under subsection (a) shall demonstrate how the proposed alternative described in paragraph (1)(A)—

''(A) makes the medical liability system more reliable by increasing the availability of prompt and fair resolution of disputes;

''(B) encourages the efficient resolution of disputes;

''(C) encourages the disclosure of health care errors;

''(D) enhances patient safety by detecting, analyzing, and helping to reduce medical errors and adverse events;

''(E) improves access to liability insurance;

''(F) fully informs patients about the differences in the alternative and current tort litigation;

''(G) provides patients the ability to opt out of or voluntarily withdraw from participating in the alternative at any time and to pursue other options, including litigation, outside the alternative;

''(H) would not conflict with State law at the time of the application in a way that would prohibit the adoption of an alternative to current tort litigation; and

''(I) would not limit or curtail a patient's existing legal rights, ability to file a claim in or access a State's legal system, or otherwise abrogate a patient's ability to file a medical malpractice claim.

''(3) SOURCES OF COMPENSATION.—Each State desiring a grant under subsection (a) shall identify the sources from and methods by which compensation would be paid for claims resolved under the proposed alternative to current tort litigation, which may include public or private funding sources, or a combination of such sources. Funding methods shall to the extent practicable provide financial incentives for activities that improve patient safety.

''(4) SCOPE.—

''(A) IN GENERAL.—Each State desiring a grant under subsection (a) shall establish a scope of jurisdiction (such as Statewide, designated geographic region, a designated area of health care practice, or a designated group of health care providers or health care organizations) for the proposed alternative to current tort litigation that is sufficient to evaluate the effects of the alternative. No scope of jurisdiction shall be established under this paragraph that is based on a health care payer or patient population.

''(B) NOTIFICATION OF PATIENTS.—A State shall demonstrate how patients would be notified that they are receiving health care services that fall within such scope, and the process by which they may opt out of or voluntarily withdraw from participating in the alternative. The decision of the patient whether to participate or continue participating in the alternative process shall be made at any time and shall not be limited in any way.

''(5) PREFERENCE IN AWARDING DEMONSTRATION GRANTS.—In awarding grants under subsection (a), the Secretary shall give preference to States—

''(A) that have developed the proposed alternative through substantive consultation with relevant stakeholders, including patient advocates, health care providers and health care organizations, attorneys with expertise in representing patients and health care providers, medical malpractice insurers, and patient safety experts;

''(B) that make proposals that are likely to enhance patient safety by detecting, analyzing, and helping to reduce medical errors and adverse events; and

''(C) that make proposals that are likely to improve access to liability insurance.

''(d) APPLICATION.—

''(1) IN GENERAL.—Each State desiring a grant under subsection (a) shall submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require.

''(2) REVIEW PANEL.—

''(A) IN GENERAL.—In reviewing applications under paragraph (1), the Secretary shall consult with a review panel composed of relevant experts appointed by the Comptroller General.

''(B) COMPOSITION.—

''(i) NOMINATIONS.—The Comptroller General shall solicit nominations from the public for individuals to serve on the review panel.

''(ii) APPOINTMENT.—The Comptroller General shall appoint, at least 9 but not more than 13, highly qualified and knowledgeable individuals to serve on the review panel and shall ensure that the following entities receive fair representation on such panel:

''(I) Patient advocates.

''(II) Health care providers and health care organizations.

''(III) Attorneys with expertise in representing patients and health care providers.

''(IV) Medical malpractice insurers.

''(V) State officials.

''(VI) Patient safety experts.

''(C) CHAIRPERSON.—The Comptroller General, or an individual within the Government Accountability Office designated by the Comptroller General, shall be the chairperson of the review panel.

''(D) AVAILABILITY OF INFORMATION.—The Comptroller General shall make available to the review panel such information, personnel, and administrative services and assistance as the review panel may reasonably require to carry out its duties.

''(E) INFORMATION FROM AGENCIES.—The review panel may request directly from any department or agency of the United States any information that such panel considers necessary to carry out its duties. To the extent consistent with applicable laws and regulations, the head of such department or agency shall furnish the requested information to the review panel.

''(e) REPORTS.—

''(1) BY STATE.—Each State receiving a grant under subsection (a) shall submit to the Secretary an annual report evaluating the effectiveness of activities funded with grants awarded under such subsection. Such report shall, at a minimum, include the impact of the activities funded on patient safety and on the availability and price of medical liability insurance.

''(2) BY SECRETARY.—The Secretary shall submit to Congress an annual compendium of the reports submitted under paragraph (1) and an analysis of the activities funded under subsection (a) that examines any differences that result from such activities in terms of the quality of care, number and nature of medical errors, medical resources used, length of time for dispute resolution, and the availability and price of liability insurance.

''(f) TECHNICAL ASSISTANCE.—

''(1) IN GENERAL.—The Secretary shall provide technical assistance to the States applying for or awarded grants under subsection (a).

''(2) REQUIREMENTS.—Technical assistance under paragraph (1) shall include—

''(A) guidance on non-economic damages, including the consideration of individual facts and circumstances in determining appropriate payment, guidance on identifying avoidable injuries, and guidance on disclosure to patients of health care errors and adverse events; and

''(B) the development, in consultation with States, of common definitions, formats, and data collection infrastructure for States receiving grants under this section to use in reporting to facilitate aggregation and analysis of data both within and between States.

''(3) USE OF COMMON DEFINITIONS, FORMATS, AND DATA COLLECTION INFRASTRUCTURE.—States not receiving grants under this section may also use the common definitions, formats, and data collection infrastructure developed under paragraph (2)(B).

''(g) EVALUATION.—

''(1) IN GENERAL.—The Secretary, in consultation with the review panel established under subsection (d)(2), shall enter into a contract with an appropriate research organization to conduct an overall evaluation of the effectiveness of grants awarded under subsection (a) and to annually prepare and submit a report to Congress. Such an evaluation shall begin not later than 18 months following the date of implementation of the first program funded by a grant under subsection (a).

''(2) CONTENTS.—The evaluation under paragraph (1) shall include—

''(A) an analysis of the effects of the grants awarded under subsection (a) with regard to the measures described in paragraph (3);

''(B) for each State, an analysis of the extent to which the alternative developed under subsection (c)(1) is effective in meeting the elements described in subsection (c)(2);

''(C) a comparison among the States receiving grants under subsection (a) of the effectiveness of the various alternatives developed by such States under subsection (c)(1);

''(D) a comparison, considering the measures described in paragraph (3), of States receiving grants approved under subsection (a) and similar States not receiving such grants; and

''(E) a comparison, with regard to the measures described in paragraph (3), of—

''(i) States receiving grants under subsection (a);

''(ii) States that enacted, prior to the date of enactment of the Patient Protection and Affordable Care Act, any cap on non-economic damages; and

''(iii) States that have enacted, prior to the date of enactment of the Patient Protection and Affordable Care Act, a requirement that the complainant obtain an opinion regarding the merit of the claim, although the substance of such opinion may have no bearing on whether the complainant may proceed with a case.

''(3) MEASURES.—The evaluations under paragraph (2) shall analyze and make comparisons on the basis of—

''(A) the nature and number of disputes over injuries allegedly caused by health care providers or health care organizations;

''(B) the nature and number of claims in which tort litigation was pursued despite the existence of an alternative under subsection (a);

''(C) the disposition of disputes and claims, including the length of time and estimated costs to all parties;

''(D) the medical liability environment;

''(E) health care quality;

''(F) patient safety in terms of detecting, analyzing, and helping to reduce medical errors and adverse events;

''(G) patient and health care provider and organization satisfaction with the alternative under subsection (a) and with the medical liability environment; and

''(H) impact on utilization of medical services, appropriately adjusted for risk.

''(4) FUNDING.—The Secretary shall reserve 5 percent of the amount appropriated in each fiscal year under subsection (k) to carry out this subsection.

''(h) MEDPAC AND MACPAC REPORTS.—

''(1) MEDPAC.—The Medicare Payment Advisory Commission shall conduct an independent review of the alternatives to current tort litigation that are implemented under grants under subsection (a) to determine the impact of such alternatives on the Medicare program under title XVIII of the Social Security Act, and its beneficiaries.

''(2) MACPAC.—The Medicaid and CHIP Payment and Access Commission shall conduct an independent review of the alternatives to current tort litigation that are implemented under grants under subsection (a) to determine the impact of such alternatives on the Medicaid or CHIP programs under titles XIX and XXI of the Social Security Act, and their beneficiaries.

''(3) REPORTS.—Not later than December 31, 2016, the Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission shall each submit to Congress a report that includes the findings and recommendations of each respective Commission based on independent reviews conducted under paragraphs (1) and (2), including an analysis of the impact of the alternatives reviewed on the efficiency and effectiveness of the respective programs.

''(i) OPTION TO PROVIDE FOR INITIAL PLANNING GRANTS.—Of the funds appropriated pursuant to subsection (k), the Secretary may use a portion not to exceed $500,000 per State to provide planning grants to such States for the development of demonstration project applications meeting the criteria described in subsection (c). In selecting States to receive such planning grants, the Secretary shall give preference to those States in which State law at the time of the application would not prohibit the adoption of an alternative to current tort litigation.

''(j) DEFINITIONS.—In this section:

''(1) HEALTH CARE SERVICES.—The term 'health care services' means any services provided by a health care provider, or by any individual working under the supervision of a health care provider, that relate to—

''(A) the diagnosis, prevention, or treatment of any human disease or impairment; or

''(B) the assessment of the health of human beings.

''(2) HEALTH CARE ORGANIZATION.—The term 'health care organization' means any individual or entity which is obligated to provide, pay for, or administer health benefits under any health plan.

''(3) HEALTH CARE PROVIDER.—The term 'health care provider' means any individual or entity—

''(A) licensed, registered, or certified under Federal or State laws or regulations to provide health care services; or

''(B) required to be so licensed, registered, or certified but that is exempted by other statute or regulation.

''(k) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $50,000,000 for the 5-fiscal year period beginning with fiscal year 2011.

''(l) CURRENT STATE EFFORTS TO ESTABLISH ALTERNATIVE TO TORT LITIGATION.—Nothing in this section shall be construed to limit any prior, current, or future efforts of any State to establish any alternative to tort litigation.

''(m) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as limiting states' authority over or responsibility for their state justice systems.''.

SEC. 10608. EXTENSION OF MEDICAL MALPRACTICE COVERAGE TO FREE CLINICS.

(a) IN GENERAL.—Section 224(o)(1) of the Public Health Service Act (42 U.S.C. 233(o)(1)) is amended by inserting after ''to an individual'' the following: '', or an officer, governing board member, employee, or contractor of a free clinic shall in providing services for the free clinic,''.

(b) EFFECTIVE DATE.—The amendment made by this section shall take effect on the date of enactment of this Act and apply to any act or omission which occurs on or after that date.

SEC. 10609. LABELING CHANGES.

Section 505(j) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)) is amended by adding at the end the following:

''(10)(A) If the proposed labeling of a drug that is the subject of an application under this subsection differs from the listed drug due to a labeling revision described under clause (i), the drug that is the subject of such application shall, notwithstanding any other provision of this Act, be eligible for approval and shall not be considered misbranded under section 502 if—

''(i) the application is otherwise eligible for approval under this subsection but for expiration of patent, an exclusivity period, or of a delay in approval described in paragraph (5)(B)(iii), and a revision to the labeling of the listed drug has been approved by the Secretary within 60 days of such expiration;

''(ii) the labeling revision described under clause (i) does not include a change to the 'Warnings' section of the labeling;

''(iii) the sponsor of the application under this subsection agrees to submit revised labeling of the drug that is the subject of such application not later than 60 days after the notification of any changes to such labeling required by the Secretary; and

''(iv) such application otherwise meets the applicable requirements for approval under this subsection.

''(B) If, after a labeling revision described in subparagraph (A)(i), the Secretary determines that the continued presence in interstate commerce of the labeling of the listed drug (as in effect before the revision described in subparagraph (A)(i)) adversely impacts the safe use of the drug, no application under this subsection shall be eligible for approval with such labeling.''.

Subtitle G—Provisions Relating to Title VIII

SEC. 10801. PROVISIONS RELATING TO TITLE VIII.

(a) Title XXXII of the Public Health Service Act, as added by section 8002(a)(1), is amended—

(1) in section 3203—

(A) in subsection (a)(1), by striking subparagraph (E);

(B) in subsection (b)(1)(C)(i), by striking ''for enrollment'' and inserting ''for reenrollment''; and

(C) in subsection (c)(1), by striking '', as part of their automatic enrollment in the CLASS program,''; and

(2) in section 3204—

(A) in subsection (c)(2), by striking subparagraph (A) and inserting the following:

''(A) receives wages or income on which there is imposed a tax under section 3101(a) or 3201(a) of the Internal Revenue Code of 1986; or'';

(B) in subsection (d), by striking ''subparagraph (B) or (C) of subsection (c)(1)'' and inserting ''subparagraph (A) or (B) of subsection (c)(2)'';

(C) in subsection (e)(2)(A), by striking ''subparagraph (A)'' and inserting ''paragraph (1)''; and

(D) in subsection (g)(1), by striking ''has elected to waive enrollment'' and inserting ''has not enrolled''.

(b) Section 8002 of this Act is amended in the heading for subsection (d), by striking ''INFORMATION ON SUPPLEMENTAL COVERAGE'' and inserting ''CLASS PROGRAM INFORMATION''.

(c) Section 6021(d)(2)(A)(iv) of the Deficit Reduction Act of 2005, as added by section 8002(d) of this Act, is amended by striking ''and coverage available'' and all that follows through ''that program,''.

Subtitle H—Provisions Relating to Title IX

SEC. 10901. MODIFICATIONS TO EXCISE TAX ON HIGH COST EMPLOYER-SPONSORED HEALTH COVERAGE.

(a) LONGSHORE WORKERS TREATED AS EMPLOYEES ENGAGED IN HIGH-RISK PROFESSIONS.—Paragraph (3) of section 4980I(f) of the Internal Revenue Code of 1986, as added by section 9001 of this Act, is amended by inserting ''individuals whose primary work is longshore work (as defined in section 258(b) of the Immigration and Nationality Act (8 U.S.C. 1288(b)), determined without regard to paragraph (2) thereof),'' before ''and individuals engaged in the construction, mining''.

(b) EXEMPTION FROM HIGH-COST INSURANCE TAX INCLUDES CERTAIN ADDITIONAL EXCEPTED BENEFITS.—Clause (i) of section 4980I(d)(1)(B) of the Internal Revenue Code of 1986, as added by section 9001 of this Act, is amended by striking ''section 9832(c)(1)(A)'' and inserting ''section 9832(c)(1) (other than subparagraph (G) thereof)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2012.

SEC. 10902. INFLATION ADJUSTMENT OF LIMITATION ON HEALTH FLEXIBLE SPENDING ARRANGEMENTS UNDER CAFETERIA PLANS.

(a) IN GENERAL.—Subsection (i) of section 125 of the Internal Revenue Code of 1986, as

added by section 9005 of this Act, is amended to read as follows:

''(i) LIMITATION ON HEALTH FLEXIBLE SPENDING ARRANGEMENTS.—

''(1) IN GENERAL.—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.

''(2) ADJUSTMENT FOR INFLATION.—In the case of any taxable year beginning after December 31, 2011, the dollar amount in paragraph (1) shall be increased by an amount equal to—

''(A) such amount, multiplied by

''(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which such taxable year begins by substituting 'calendar year 2010' for 'calendar year 1992' in subparagraph (B) thereof. If any increase determined under this paragraph is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2010.

SEC. 10903. MODIFICATION OF LIMITATION ON CHARGES BY CHARITABLE HOSPITALS.

(a) IN GENERAL.—Subparagraph (A) of section 501(r)(5) of the Internal Revenue Code of 1986, as added by section 9007 of this Act, is amended by striking ''the lowest amounts charged'' and inserting ''the amounts generally billed''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after the date of the enactment of this Act.

SEC. 10904. MODIFICATION OF ANNUAL FEE ON MEDICAL DEVICE MANUFACTURERS AND IMPORTERS.

(a) IN GENERAL.—Section 9009 of this Act is amended—

(1) by striking ''2009'' in subsection (a)(1) and inserting ''2010'',

(2) by inserting ''($3,000,000,000 after 2017)'' after ''$2,000,000,000'', and

(3) by striking ''2008'' in subsection (i) and inserting ''2009''.

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect as if included in the enactment of section 9009.

SEC. 10905. MODIFICATION OF ANNUAL FEE ON HEALTH INSURANCE PROVIDERS.

(a) DETERMINATION OF FEE AMOUNT.—Subsection (b) of section 9010 of this Act is amended to read as follows:

''(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 the applicable amount as—

''(A) 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, bears to

''(B) 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.

''(2) AMOUNTS TAKEN INTO ACCOUNT.—For purposes of paragraph (1), 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.

''(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 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.''.

(b) APPLICABLE AMOUNT.—Subsection (e) of section 9010 of this Act is amended to read as follows:

''(e) APPLICABLE AMOUNT.—For purposes of subsection (b)(1), the applicable amount shall be determined in accordance with the following table:

"Calendar year	Applicable amount
2011	$2,000,000,000
2012	$4,000,000,000
2013	$7,000,000,000
2014, 2015 and 2016	$9,000,000,000
2017 and thereafter	$10,000,000,000.''.

(c) EXEMPTION FROM ANNUAL FEE ON HEALTH INSURANCE FOR CERTAIN NONPROFIT ENTITIES.—Section 9010(c)(2) of this Act is amended by striking ''or'' at the end of subparagraph (A), by striking the period at the end of subparagraph (B) and inserting a comma, and by adding at the end the following new subparagraphs:

''(C) any entity—

''(i)(I) which is incorporated as, is a wholly owned subsidiary of, or is a wholly owned affiliate of, a nonprofit corporation under a State law, or

''(II) which is described in section 501(c)(4) of the Internal Revenue Code of 1986 and the activities of which consist of providing commercial-type insurance (within the meaning of section 501(m) of such Code),

''(ii) the premium rate increases of which are regulated by a State authority,

''(iii) which, as of the date of the enactment of this section, acts as the insurer of last resort in the State and is subject to State guarantee issue requirements, and

''(iv) for which the medical loss ratio (determined in a manner consistent with the determination of such ratio under section 2718(b)(1)(A) of the Public Health Service Act) with respect to the individual insurance market for such entity for the calendar year is not less than 100 percent,

''(D) any entity—

''(i)(I) which is incorporated as a nonprofit corporation under a State law, or

''(II) which is described in section 501(c)(4) of the Internal Revenue Code of 1986 and the activities of which consist of providing commercial-type insurance (within the meaning of section 501(m) of such Code), and

''(ii) for which the medical loss ratio (as so determined)—

''(I) with respect to each of the individual, small group, and large group insurance markets for such entity for the calendar year is not less than 90 percent, and

''(II) with respect to all such markets for such entity for the calendar year is not less than 92 percent, or

''(E) any entity—

''(i) which is a mutual insurance company,

''(ii) which for the period reported on the 2008 Accident and Health Policy Experience Exhibit of the National Association of Insurance Commissioners had—

''(I) a market share of the insured population of a State of at least 40 but not more than 60 percent, and

''(II) with respect to all markets described in subparagraph (D)(ii)(I), a medical loss ratio of not less than 90 percent, and

''(iii) with respect to annual payment dates in calendar years after 2011, for which the medical loss ratio (determined in a manner consistent with the determination of such ratio under section 2718(b)(1)(A) of the Public Health Service Act) with respect to all such markets for such entity for the preceding calendar year is not less than 89 percent (except that with respect to such annual payment date for 2012, the calculation under 2718(b)(1)(B)(ii) of such Act is determined by reference to the previous year, and with respect to such annual payment date for 2013, such calculation is determined by reference to the average for the previous 2 years).''.

(d) CERTAIN INSURANCE EXEMPTED FROM FEE.—Paragraph (3) of section 9010(h) of this Act is amended to read as follows:

''(3) HEALTH INSURANCE.—The term 'health insurance' shall not include—

''(A) any insurance coverage described in paragraph (1)(A) or (3) of section 9832(c) of the Internal Revenue Code of 1986,

''(B) any insurance for long-term care, or

''(C) any medicare supplemental health insurance (as defined in section 1882(g)(1) of the Social Security Act).''.

(e) ANTI-AVOIDANCE GUIDANCE.—Subsection (i) of section 9010 of this Act is amended by inserting ''and shall prescribe such regulations as are necessary or appropriate to prevent avoidance of the purposes of this section, including inappropriate actions taken

to qualify as an exempt entity under subsection (c)(2)'' after ''section''.

(f) CONFORMING AMENDMENTS.—

(1) Section 9010(a)(1) of this Act is amended by striking ''2009'' and inserting ''2010''.

(2) Section 9010(c)(2)(B) of this Act is amended by striking ''(except'' and all that follows through ''1323)''.

(3) Section 9010(c)(3) of this Act is amended by adding at the end the following new sentence: ''If any entity described in subparagraph (C)(i)(I), (D)(i)(I), or (E)(i) of paragraph (2) is treated as a covered entity by reason of the application of the preceding sentence, the net premiums written with respect to health insurance for any United States health risk of such entity shall not be taken into account for purposes of this section.''.

(4) Section 9010(g)(1) of this Act is amended by striking ''and third party administration agreement fees''.

(5) Section 9010(j) of this Act is amended—

(A) by striking ''2008'' and inserting ''2009'', and

(B) by striking '', and any third party administration agreement fees received after such date''.

(g) EFFECTIVE DATE.—The amendments made by this section shall take effect as if included in the enactment of section 9010.

SEC. 10906. MODIFICATIONS TO ADDITIONAL HOSPITAL INSURANCE TAX ON HIGH-INCOME TAXPAYERS.

(a) FICA.—Section 3101(b)(2) of the Internal Revenue Code of 1986, as added by section 9015(a)(1) of this Act, is amended by striking ''0.5 percent'' and inserting ''0.9 percent''.

(b) SECA.—Section 1401(b)(2)(A) of the Internal Revenue Code of 1986, as added by section 9015(b)(1) of this Act, is amended by striking ''0.5 percent'' and inserting ''0.9 percent''.

(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. 10907. EXCISE TAX ON INDOOR TANNING SERVICES IN LIEU OF ELECTIVE COSMETIC MEDICAL PROCEDURES.

(a) IN GENERAL.—The provisions of, and amendments made by, section 9017 of this Act are hereby deemed null, void, and of no effect.

(b) EXCISE TAX ON INDOOR TANNING SERVICES.—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—COSMETIC SERVICES

''Sec. 5000B. Imposition of tax on indoor tanning services.

''SEC. 5000B. IMPOSITION OF TAX ON INDOOR TANNING SERVICES.

''(a) IN GENERAL.—There is hereby imposed on any indoor tanning service a tax equal to 10 percent of the amount paid for such service (determined without regard to this section), whether paid by insurance or otherwise.

''(b) INDOOR TANNING SERVICE.—For purposes of this section—

''(1) IN GENERAL.—The term 'indoor tanning service' means a service employing any electronic product designed to incorporate 1 or more ultraviolet lamps and intended for the irradiation of an individual by ultraviolet radiation, with wavelengths in air between 200 and 400 nanometers, to induce skin tanning.

''(2) EXCLUSION OF PHOTOTHERAPY SERVICES.—Such term does not include any phototherapy service performed by a licensed medical professional.

''(c) PAYMENT OF TAX.—

''(1) IN GENERAL.—The tax imposed by this section shall be paid by the individual on whom the service is performed.

''(2) COLLECTION.—Every person receiving a payment for services on which a tax is imposed under subsection (a) shall collect the amount of the tax from the individual on whom the service 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 indoor tanning services are made, then to the extent that such tax is not collected, such tax shall be paid by the person who performs the service.''.

(c) CLERICAL AMENDMENT.—The table of chapter 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—COSMETIC SERVICES''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to services performed on or after July 1, 2010.

SEC. 10908. EXCLUSION FOR ASSISTANCE PROVIDED TO PARTICIPANTS IN STATE STUDENT LOAN REPAYMENT PROGRAMS FOR CERTAIN HEALTH PROFESSIONALS.

(a) IN GENERAL.—Paragraph (4) of section 108(f) of the Internal Revenue Code of 1986 is amended to read as follows:

''(4) PAYMENTS UNDER NATIONAL HEALTH SERVICE CORPS LOAN REPAYMENT PROGRAM AND CERTAIN STATE LOAN REPAYMENT PROGRAMS.—In the case of an individual, gross income shall not include any amount received under section 338B(g) of the Public Health Service Act, under a State program described in section 338I of such Act, or under any other State loan repayment or loan forgiveness program that is intended to provide for the increased availability of health care services in underserved or health professional shortage areas (as determined by such State).''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to amounts received by an individual in taxable years beginning after December 31, 2008.

SEC. 10909. EXPANSION OF ADOPTION CREDIT AND ADOPTION ASSISTANCE PROGRAMS.

(a) INCREASE IN DOLLAR LIMITATION.—

(1) ADOPTION CREDIT.—

(A) IN GENERAL.—Paragraph (1) of section 23(b) of the Internal Revenue Code of 1986 (relating to dollar limitation) is amended by striking ''$10,000'' and inserting ''$13,170''.

(B) CHILD WITH SPECIAL NEEDS.—Paragraph (3) of section 23(a) of such Code (relating to $10,000 credit for adoption of child with special needs regardless of expenses) is amended—

(i) in the text by striking ''$10,000'' and inserting ''$13,170'', and

(ii) in the heading by striking ''$10,000'' and inserting ''$13,170''.

(C) CONFORMING AMENDMENT TO INFLATION ADJUSTMENT.—Subsection (h) of section 23 of such Code (relating to adjustments for inflation) is amended to read as follows:

''(h) ADJUSTMENTS FOR INFLATION.—

''(1) DOLLAR LIMITATIONS.—In the case of a taxable year beginning after December 31, 2010, each of the dollar amounts in subsections (a)(3) and (b)(1) shall be increased by an amount equal to—

''(A) such dollar amount, multiplied by

''(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, determined by substituting 'calendar year 2009' for 'calendar year 1992' in subparagraph (B) thereof.

If any amount as increased under the preceding sentence is not a multiple of $10, such amount shall be rounded to the nearest multiple of $10.

''(2) INCOME LIMITATION.—In the case of a taxable year beginning after December 31, 2002, the dollar amount in subsection (b)(2)(A)(i) shall be increased by an amount equal to—

''(A) such dollar amount, multiplied by

''(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, determined by substituting 'calendar year 2001' for 'calendar year 1992' in subparagraph (B) thereof.

If any amount as increased under the preceding sentence is not a multiple of $10, such amount shall be rounded to the nearest multiple of $10.''.

(2) ADOPTION ASSISTANCE PROGRAMS.—

(A) IN GENERAL.—Paragraph (1) of section 137(b) of the Internal Revenue Code of 1986 (relating to dollar limitation) is amended by striking ''$10,000'' and inserting ''$13,170''.

(B) CHILD WITH SPECIAL NEEDS.—Paragraph (2) of section 137(a) of such Code (relating to $10,000 exclusion for adoption of child with special needs regardless of expenses) is amended—

(i) in the text by striking ''$10,000'' and inserting ''$13,170'', and

(ii) in the heading by striking ''$10,000'' and inserting ''$13,170''.

(C) CONFORMING AMENDMENT TO INFLATION ADJUSTMENT.—Subsection (f) of section 137 of such Code (relating to adjustments for inflation) is amended to read as follows:

''(f) ADJUSTMENTS FOR INFLATION.—

''(1) DOLLAR LIMITATIONS.—In the case of a taxable year beginning after December 31, 2010, each of the dollar amounts in subsections (a)(2) and (b)(1) shall be increased by an amount equal to—

''(A) such dollar amount, multiplied by

''(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, determined by substituting 'calendar year 2009' for 'calendar year 1992' in subparagraph (B) thereof.

If any amount as increased under the preceding sentence is not a multiple of $10, such amount shall be rounded to the nearest multiple of $10.

''(2) INCOME LIMITATION.—In the case of a taxable year beginning after December 31, 2002, the dollar amount in subsection (b)(2)(A) shall be increased by an amount equal to—

''(A) such dollar amount, multiplied by

''(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, determined by substituting 'calendar year 2001' for 'calendar year 1992' in subparagraph thereof.

If any amount as increased under the preceding sentence is not a multiple of $10, such amount shall be rounded to the nearest multiple of $10.''.

(b) CREDIT MADE REFUNDABLE.—

(1) CREDIT MOVED TO SUBPART RELATING TO REFUNDABLE CREDITS.—The Internal Revenue Code of 1986 is amended—

(A) by redesignating section 23, as amended by subsection (a), as section 36C, and

(B) by moving section 36C (as so redesignated) from subpart A of part IV of subchapter A of chapter 1 to the location immediately before section 37 in subpart C of part IV of subchapter A of chapter 1.

(2) CONFORMING AMENDMENTS.—

(A) Section 24(b)(3)(B) of such Code is amended by striking ''23,''.

(B) Section 25(e)(1)(C) of such Code is amended by striking ''23,'' both places it appears.

(C) Section 25A(i)(5)(B) of such Code is amended by striking ''23, 25D,'' and inserting ''25D''.

(D) Section 25B(g)(2) of such Code is amended by striking ''23,''.

(E) Section 26(a)(1) of such Code is amended by striking ''23,''.

(F) Section 30(c)(2)(B)(ii) of such Code is amended by striking ''23, 25D,'' and inserting ''25D''.

(G) Section 30B(g)(2)(B)(ii) of such Code is amended by striking ''23,''.

(H) Section 30D(c)(2)(B)(ii) of such Code is amended by striking ''sections 23 and'' and inserting ''section''.

(I) Section 36C of such Code, as so redesignated, is amended—

(i) by striking paragraph (4) of subsection (b), and

(ii) by striking subsection (c).

(J) Section 137 of such Code is amended—

(i) by striking ''section 23(d)'' in subsection (d) and inserting ''section 36C(d)'', and

(ii) by striking ''section 23'' in subsection (e) and inserting ''section 36C''.

(K) Section 904(i) of such Code is amended by striking ''23,''.

(L) Section 1016(a)(26) is amended by striking ''23(g)'' and inserting ''36C(g)''.

(M) Section 1400C(d) of such Code is amended by striking ''23,''.

(N) Section 6211(b)(4)(A) of such Code is amended by inserting ''36C,'' before ''53(e)''.

(O) The table of sections for subpart A of part IV of subchapter A of chapter 1 of such Code of 1986 is amended by striking the item relating to section 23.

(P) Paragraph (2) of section 1324(b) of title 31, United States Code, as amended by this Act, is amended by inserting ''36C,'' after ''36B,''.

(Q) The table of sections for subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986, as amended by this Act, is amended by inserting after the item relating to section 36B the following new item:

''Sec. 36C. Adoption expenses.''.

(c) APPLICATION AND EXTENSION OF EGTRRA SUNSET.—Notwithstanding section 901 of the Economic Growth and Tax Relief Reconciliation Act of 2001, such section shall apply to the amendments made by this section and the amendments made by section 202 of such Act by substituting ''December 31, 2011'' for ''December 31, 2010'' in subsection (a)(1) thereof.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2009.

SA 3277. Mr. REID proposed an amendment to amendment SA 3276 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill 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; as follows:

At the end of the amendment, add the following:

The provisions of this Act shall become effective 5 days after enactment.

SA 3278. Mr. REID proposed an amendment to the bill 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; as follows:

At the end of the language proposed to be stricken, insert the following:

This section shall become effective 4 days after enactment.

SA 3279. Mr. REID proposed an amendment to amendment SA 3278 proposed by Mr. REID to the bill 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; as follows:

In the amendment, strike ''4'' and insert ''3''.

SA 3280. Mr. REID proposed an amendment to the bill 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; as follows:

At the end, insert the following:

The provisions of this Act shall become effective 2 days after enactment.

SA 3281. Mr. REID proposed an amendment to amendment SA 3280 proposed by Mr. REID to the bill 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; as follows:

Strike ''2 days'' and insert ''1 day''.

SA 3282. Mr. REID proposed an amendment to amendment SA 3281 proposed by Mr. REID to the amendment SA 3280 proposed by Mr. REID to the bill 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; as follows:

Strike ''1 day'' and insert ''immediately''.

SA 3283. Mr. COBURN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill 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; which was ordered to lie on the table; as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Patients' Choice Act''.

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

Sec. 1. Short title; table of contents.

TITLE I—INVESTING IN PREVENTION

Sec. 101. Strategic approach to outcome-based prevention.
Sec. 102. State grants for outcome-based prevention effort.
Sec. 103. Focusing the food stamp program on nutrition.
Sec. 104. Immunizations.

TITLE II—STATE-BASED HEALTH CARE EXCHANGES

Sec. 201. State-based health care exchanges.
Sec. 202. Requirements.
Sec. 203. State Exchange incentives.

TITLE III—FAIR TAX TREATMENT FOR ALL AMERICANS TO AFFORD HEALTH CARE

Sec. 300. Reference.
Sec. 301. Refundable and advanceable credit for certain health insurance coverage.
Sec. 302. Requiring employer transparency about employee benefits.
Sec. 303. Changes to existing tax preferences for medical coverage, etc., for individuals eligible for qualified health insurance credit.
Sec. 304. Adjustments.

TITLE IV—FAIRNESS FOR EVERY AMERICAN PATIENT

Subtitle A—Medicaid Modernization

Sec. 401. Medicaid modernization.
Sec. 402. Outreach.
Sec. 403. Transition rules; miscellaneous provisions.

Subtitle B—Supplemental Health Care Assistance for Low-Income Families

Sec. 411. Supplemental Health Care Assistance for Low-Income Families.

TITLE V—FIXING MEDICARE FOR AMERICAN SENIORS

Subtitle A—Increasing Programmatic Efficiency, Economy, and Accountability

Sec. 501. Eliminating inefficiencies and increasing choice in Medicare Advantage.
Sec. 502. Medicare Accountable Care Organization demonstration program.
Sec. 503. Reducing government handouts to wealthier seniors.
Sec. 504. Rewarding prevention.
Sec. 505. Promoting healthcare provider transparency.
Sec. 506. Availability of Medicare and Medicaid claims and patient encounter data.

Subtitle B—Reducing Fraud and Abuse

Sec. 511. Requiring the Secretary of Health and Human Services to change the Medicare beneficiary identifier used to identify Medicare beneficiaries under the Medicare program.
Sec. 512. Use of technology for real-time data review.
Sec. 513. Detection of medicare fraud and abuse.
Sec. 514. Edits on 855S Medicare enrollment application and exemption of pharmacists from surety bond requirement.
Sec. 515. GAO study and report on effectiveness of surety bond requirements for suppliers of durable medical equipment in combating fraud.

TITLE VI—ENDING LAWSUIT ABUSE

Sec. 601. State grants to create health court solutions.

TITLE VII—PROMOTING HEALTH INFORMATION TECHNOLOGY

Subtitle A—Assisting the Development of Health Information Technology

Sec. 701. Purpose.
Sec. 702. Health record banking.
Sec. 703. Application of Federal and State security and confidentiality standards.

Subtitle B—Removing Barriers to the Use of Health Information Technology to Better Coordinate Health Care

Sec. 711. Safe harbors to antikickback civil penalties and criminal penalties for provision of health information technology and training services.

Sec. 712. Exception to limitation on certain physician referrals (under Stark) for provision of health information technology and training services to health care professionals.
Sec. 713. Rules of construction regarding use of consortia.

TITLE VIII—HEALTH CARE SERVICES COMMISSION

Subtitle A—Establishment and General Duties

Sec. 801. Establishment.
Sec. 802. General authorities and duties.
Sec. 803. Dissemination.

Subtitle B—Forum for Quality and Effectiveness in Health Care

Sec. 811. Establishment of office.
Sec. 812. Membership.
Sec. 813. Duties.
Sec. 814. Adoption and enforcement of guidelines and standards.
Sec. 815. Additional requirements.

Subtitle C—General Provisions

Sec. 821. Certain administrative authorities.
Sec. 822. Funding.
Sec. 823. Definitions.

Subtitle D—Terminations and Transition

Sec. 831. Termination of Agency for Healthcare Research and Quality.
Sec. 832. Transition.

Subtitle E—Independent Health Record Trust

Sec. 841. Short title.
Sec. 842. Purpose.
Sec. 843. Definitions.
Sec. 844. Establishment, certification, and membership of Independent Health Record Trusts.
Sec. 845. Duties of IHRT to IHRT participants.
Sec. 846. Availability and use of information from records in IHRT consistent with privacy protections and agreements.
Sec. 847. Voluntary nature of trust participation and information sharing.
Sec. 848. Financing of activities.
Sec. 849. Regulatory oversight.

TITLE IX—MISCELLANEOUS

Sec. 901. Health care choice for veterans.
Sec. 902. Health care choice for Indians.
Sec. 903. Termination of Federal Coordinating Council for Comparative Effectiveness Research.
Sec. 904. HHS and GAO joint study and report on costs of the 5 medical conditions that have the greatest impact.
Sec. 905. Conscience protection.
Sec. 906. Nondiscrimination on abortion and respect for rights of conscience
Sec. 907. Prohibition on government entities using comparative effectiveness research for certain purposes.
Sec. 908. Solvency of Medicare program.
Sec. 909. To ensure patients receive doctor recommendations for preventive health services, including mammograms and cervical cancer screening, without interference from government or insurance company bureaucrats.
Sec. 910. Ensuring that government health care rationing does not harm, injure, or deny medically necessary care.
Sec. 911. Identification of Federal Government health care rationing.
Sec. 912. Using health care professionals to reduce fraud.

TITLE I—INVESTING IN PREVENTION

SEC. 101. STRATEGIC APPROACH TO OUTCOME-BASED PREVENTION.

(a) INTERAGENCY COORDINATING COMMITTEE.—

(1) IN GENERAL.—The Secretary of Health and Human Services (referred to in this title as the ''Secretary'') shall convene an interagency coordinating committee to develop a national strategic plan for prevention. The Secretary shall serve as the chairperson of the committee.

(2) COMPOSITION.—In carrying out paragraph (1), the Secretary shall include the participation of—

(A) the Director of the National Institutes of Health;

(B) the Director of the Centers for Disease Control and Prevention;

(C) the Administrator of the Agency for Healthcare Research and Quality;

(D) the Administrator of the Substance Abuse and Mental Health Services Administration;

(E) the Administrator of the Health Resources and Services Administration;

(F) the Secretary of Agriculture;

(G) the Director of the Centers for Medicare & Medicaid Services;

(H) the Administrator of the Environmental Protection Agency;

(I) the Director of the Indian Health Service;

(J) the Administrator of the Administration on Aging;

(K) the Secretary of Veterans Affairs;

(L) the Secretary of Defense;

(M) the Secretary of Education; and

(N) the Secretary of Labor.

(3) REPORT AND PLAN.—Not later than 1 year after the date of enactment of this Act, the Secretary, acting through the coordinating committee convened under paragraph (1), shall submit to Congress a report concerning the recommendation of the committee for health promotion and disease prevention activities. Such report shall include a specific strategic plan that shall include—

(A) a list of national priorities on health promotion and disease prevention to address lifestyle behavior modification (smoking cessation, proper nutrition, and appropriate exercise) and the prevention measures for the 5 leading disease killers in the United States;

(B) 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;

(C) 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), that include transferring the nutrition guideline development responsibility from the Secretary of Agriculture to the Director of the Centers for Disease Control and Prevention;

(D) specific plans to ensure that all Federal health care programs are fully coordinated with science-based prevention recommendations promulgated by the Director of the Centers for Disease Control and Prevention;

(E) specific plans to ensure that all non-Department of Health and Human Services prevention programs are based on the science-based guidelines developed by the Centers for Disease Control and Prevention under subparagraph (D); and

(F) a list of new non-Federal and non-government partners identified by the committee to build Federal capacity in health promotion and disease prevention efforts.

(4) ANNUAL REQUEST TO GIVE TESTIMONY.—The Secretary shall annually request an opportunity to testify before Congress concerning the progress made by the United States in meeting the outcome-based standards of Healthy People 2010 with respect to disease prevention and measurable outcomes and effectiveness of Federal programs related to this goal.

(5) PERIODIC REVIEWS.—The Secretary shall conduct periodic reviews, not less than every 5 years, and grading of every Federal disease prevention and health promotion initiatives, programs, and agencies. Such reviews shall be evaluated based on effectiveness in meeting metrics-based goals with an analysis posted on such agencies' public Internet websites.

(b) FEDERAL MESSAGING ON HEALTH PROMOTION AND DISEASE PREVENTION.—

(1) MEDIA CAMPAIGNS.—

(A) 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.

(B) REQUIREMENTS OF CAMPAIGN.—The campaign implemented under subparagraph (A)—

(i) 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;

(ii) shall be carried out through competitively bid contracts awarded to entities providing for the professional production and design of such campaign;

(iii) 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;

(iv) shall not be duplicative of any other Federal efforts relating to health promotion and disease prevention; and

(v) may include the use of humor and nationally recognized positive role models.

(C) EVALUATION.—The Secretary shall ensure that the campaign implemented under subparagraph (A) 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.

(2) WEBSITE.—The Secretary, in consultation with private-sector experts, shall maintain or enter into a contract to maintain an Internet website to provide science-based information on guidelines for nutrition, regular exercise, obesity reduction, smoking cessation, and specific chronic disease prevention. Such website shall be designed to provide information to health care providers and consumers.

(3) DISSEMINATION OF INFORMATION THROUGH PROVIDERS.—The Secretary, acting through the Centers for Disease Control and Prevention, shall develop and implement a plan for the dissemination of health promotion and disease prevention information consistent with national priorities described in the strategic and implementing plan under subsection (a)(3)(A), to health care providers who participate in Federal programs, including programs administered by the Indian Health Service, the Department of Veterans Affairs, the Department of Defense, and the Health Resources and Services Administration, and the Medicare and Medicaid Programs.

(4) PERSONALIZED PREVENTION PLANS.—

(A) CONTRACT.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall enter into a contract with a qualified entity for the development and operation of a Federal Internet website personalized prevention plan tool.

(B) USE.—The website developed under subparagraph (A) shall be designed to be used as a source of the most up-to-date scientific evidence relating to disease prevention for

use by individuals. Such website shall contain a component that enables an individual to determine their disease risk (based on personal health and family history, BMI, and other relevant information) relating to the 5 leading diseases in the United States, and obtain personalized suggestions for preventing such diseases.

(5) INTERNET PORTAL.—The Secretary shall establish an Internet portal for accessing risk-assessment tools developed and maintained by private and academic entities.

(6) PRIORITY FUNDING.—Funding for the activities authorized under this section shall take priority over funding from the Centers for Disease Control and Prevention provided for grants to States and other entities for similar purposes and goals as provided for in this section. Not to exceed $500,000,000 shall be expended on the campaigns and activities required under this Act.

SEC. 102. STATE GRANTS FOR OUTCOME-BASED PREVENTION EFFORT.

(a) IN GENERAL.—If the Secretary determines that it is essential to meeting the national priorities described in the plan required under section 101(a)(3)(A), the Secretary may award grants to States for the conduct of specific health promotion and disease prevention activities.

(b) ELIGIBILITY.—To be eligible to receive a grant under subsection (a), a State shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including a strategic plan that shall—

(1) describe the specific health promotion and disease prevention activities to be carried out under this grant;

(2) include a list of the barriers that exist within the State to meeting specific goals of Healthy People 2010;

(3) include targeted demographic indicators and measurable objectives with respect to health promotion and disease prevention;

(4) contain a set of process outcomes and milestones, based on the process outcomes and milestones developed by the Secretary, for measuring the effectiveness of activities carried out under the grant in the State; and

(5) outline the manner in which interventions to be carried out under this grant will reduce morbidity and mortality within the State over a 5-year period (or over a 10-year period, if the Secretary determines such period appropriate for adequately measuring progress).

(c) PROCESS OUTCOMES AND MILESTONES.—

(1) IN GENERAL.—The Secretary shall develop process outcomes and milestones to be used to measure the effectiveness of activities carried out under a grant under this section by a State.

(2) DETERMINATIONS.—If, beginning 2 years after the date on which a grant is awarded to a State under this section, the Secretary determines that the State is failing to make adequate progress in meeting the outcomes and milestones contained in the State plan under subsection (b)(4), the Secretary shall provide the State with technical assistance on how to make such progress. Such technical assistance shall continue for a period of 2 years.

(3) CONTINUED FAILURE TO MEET OBJECTIVES.—If after the expiration of the 2-year period described in paragraph (2), the Secretary determines that the State is failing to make adequate progress in meeting the outcomes and milestones contained in the State plan under subsection (b)(4) over a 5-year period, the Secretary shall terminate all funding to the State under a grant under this section.

(d) REGIONAL ACTIVITIES.—A State may use an amount, not to exceed 15 percent of the total grant amount to such State, to carry out regional activities in conjunction with other States.

(e) TARGETED ACTIVITIES.—A State may use grant funds to target specific populations within the State to achieve specific outcomes described in Healthy People 2010.

(f) INNOVATIVE INCENTIVE STRUCTURES.—The Secretary may award grants to States for the purposes of developing innovative incentive structures to encourage individuals to adopt specific prevention behaviors such as reducing their body mass index or for smoking cessation.

(g) WELLNESS BONUSES.—

(1) IN GENERAL.—The Secretary shall award wellness bonus payments to at least 5, but not more than 10, States that demonstrate the greatest progress in reducing disease rates and risk factors and increasing heathy behaviors.

(2) REQUIREMENT.—To be eligible to receive a bonus payment under paragraph (1), a State shall demonstrate—

(A) the progress described in paragraph (1); and

(B) that the State has met a specific floor for progress outlined in the science-based metrics of Healthy People 2010.

(3) USE OF PAYMENTS.—Bonus payments under this subsection may only be used by a State for the purposes of health promotion and disease prevention.

(4) FUNDING.—Out of funds appropriated to the Director of the Centers for Disease Control and Prevention for each fiscal year beginning with fiscal year 2010, the Director shall give priority to using $50,000,000 of such funds to make bonus payments under this subsection.

(h) ADMINISTRATIVE EXPENSES.—A State may use not more than 5 percent of the amount of a grant under this section to carry out administrative activities.

(i) STATE.—In this section, the term ''State'' means the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, Samoa, the United States Virgin Islands, and the Commonwealth of the Northern Mariana Islands.

(j) AUTHORIZATION OF APPROPRIATIONS.—Funding for the activities authorized under this section shall take priority over funding from the Centers for Disease Control and Prevention provided for grants to States and other entities for similar purposes and goals as provided for in this section, not to exceed $300,000,000 for each fiscal year.

SEC. 103. FOCUSING THE FOOD STAMP PROGRAM ON NUTRITION.

(a) COUNSELING BROCHURE.—The Director of the Centers for Disease Control and Prevention shall develop, and the Secretary of Agriculture shall distribute to each individual and family enrolled in the Food Stamp Program under the Food Stamp Act of 1977 (7 U.S.C. 2011 et seq.), a science-based nutrition counseling brochure.

(b) LIMITATIONS ON FOOD STAMP PURCHASES.—

(1) IN GENERAL.—Not later than 6 months after the date of enactment of this Act, the Secretary of Agriculture shall, based on scientific, peer-reviewed recommendations provided by a Commission that includes public health, medical, and nutrition experts and the Director of the Centers for Disease Control and Prevention, develop lists of foods that do not meet science-based standards for proper nutrition and that may not be purchased under the food stamp program. Such list shall be updated on an annual basis to ensure the most current science-based recommendations are applied to the food stamp program.

(2) AUTOMATED ENFORCEMENT.—The Secretary of Agriculture shall, through regulations, ensure that the limitations on food purchases under paragraph (1) is enforced through the food stamp program's automated system.

(3) IMPLEMENTATION.—The Secretary of Agriculture shall promulgate the regulations described in paragraph (2) by the date that is not later than 1 year after the date of enactment of this section.

SEC. 104. IMMUNIZATIONS.

(a) PURCHASE OF VACCINES.—Notwithstanding any other provision of law, a State may use amounts provided under section 317 of the Public Health Service Act (42 U.S.C. 247b) for immunization programs to purchase vaccines for use in health care provider offices and schools.

(b) TECHNICAL ASSISTANCE AND REDUCTION IN FUNDING.—If a State does not achieve a benchmark of 80 percent coverage within the State for Centers for Disease Control and Prevention-recommended vaccines, the Director of the Centers shall provide technical assistance to the State for a period of 2 years. If after the expiration of such 2-year period the State continues to fail to achieve such benchmark, the Secretary shall reduce funding provided under section 317 of the Public Health Service Act to such State by 5 percent.

(c) BONUS GRANT.—A State achieving a benchmark of 90 percent or greater coverage within the State for Centers for Disease Control and Prevention-recommended vaccines shall be eligible for a bonus grant from amounts appropriated under subsection (d).

(d) AUTHORIZATION OF APPROPRIATIONS.—Out of funds appropriated to the Director of the Centers for Disease Control and Prevention for each fiscal year beginning with fiscal year 2010, there shall be made available to carry out this section, $50,000,000 for each fiscal year.

(e) FUNDING FOR SECTION 317.—Section 317(j)(1) of the Public Health Service Act (42 U.S.C. 247b(j)(1)) is amended by striking ''2005'' and inserting ''2012''.

TITLE II—STATE-BASED HEALTH CARE EXCHANGES

SEC. 201. STATE-BASED HEALTH CARE EXCHANGES.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this title as the ''Secretary'') shall establish a process for the review of applications submitted by States for the establishment and implementation of State-based health care Exchanges (referred to in this title as a ''State Exchange'') and for the certification of such Exchanges. The Secretary shall certify a State Exchange if the Secretary determines that such Exchange meets the requirements of this title.

(b) CONTINUED CERTIFICATION.—The certification of a State Exchange under subsection (a) shall remain in effect until the Secretary determines that the Exchange has failed to meet any of the requirements under this title.

SEC. 202. REQUIREMENTS.

(a) GENERAL REQUIREMENTS FOR CERTIFICATION.—An application for certification under section 201(a) shall demonstrate compliance with the following:

(1) PURPOSE.—The primary purpose of a State Exchange shall be the facilitation of the individual purchase of innovative private health insurance and the creation of a market where private health plans compete for enrollees based on price and quality.

(2) ADMINISTRATION.—A State shall ensure the operation of the State Exchange through direct contracts with the health insurance plans that are participating in the State Exchange or through a contract with a third party administrator for the operation of the Exchange.

(3) PLAN PARTICIPATION.—A State shall not restrict or otherwise limit the ability of a

health insurance plan to participate in, and offer health insurance coverage through, the State Exchange, so long as the health insurance issuers involved are duly licensed under State insurance laws applicable to all health insurance issuers in the State and otherwise comply with the requirements of this title.

(4) PREMIUMS.—

(A) AMOUNT.—A State shall not determine premium or cost sharing amounts for health insurance coverage offered through the State Exchange.

(B) COLLECTION METHOD.—A State shall ensure the existence of an effective and efficient method for the collection of premiums for health insurance coverage offered through the State Exchange.

(b) BENEFIT PARITY WITH MEMBERS OF CONGRESS.—With respect to health insurance issuers offering health insurance coverage through the State Exchange, the State shall not impose any requirement that such issuers provide coverage that includes benefits different than requirements on plans offered to Members of Congress under chapter 89 of title 5, United States Code.

(c) FACILITATING UNIVERSAL COVERAGE FOR AMERICANS.—

(1) AUTOMATIC ENROLLMENT.—The State Exchange shall ensure that health insurance coverage offered through the Exchange provides for the application of uniform mechanisms that are designed to encourage and facilitate the enrollment of all eligible individuals in Exchange-based health insurance coverage. Such mechanisms shall include automatic enrollment through various venues, which may include emergency rooms, the submission of State tax forms, places of employment in the State, and State departments of motor vehicles.

(2) OTHER ENROLLMENT OPPORTUNITIES.—

(A) IN GENERAL.—The State Exchange shall ensure that health insurance coverage offered through the Exchange permits enrollment, and changes in enrollment, of individuals at the time such individuals become eligible individuals in the State.

(B) ANNUAL OPEN ENROLLMENT PERIODS.—The State Exchange shall ensure that health insurance coverage offered through the Exchange permits eligible individuals to annually change enrollment among the coverage offered through the Exchange, subject to subparagraph (A).

(C) INCENTIVES FOR CONTINUOUS ANNUAL COVERAGE.—The State Exchange shall include an incentive for eligible individuals to remain insured from plan year to plan year, and may include incentives such as State tax incentives or premium-based incentives.

(3) GUARANTEED ACCESS FOR INDIVIDUALS.—The State Exchange shall ensure that, with respect to health insurance coverage offered through the Exchange, all eligible individuals are able to enroll in the coverage of their choice provided that such individuals agree to make applicable premium and cost sharing payments.

(4) LIMITATION ON PRE-EXISTING CONDITION EXCLUSIONS.—The State Exchange shall ensure that health insurance coverage offered through the Exchange meets the requirements of section 9801 of the Internal Revenue Code of 1986 in the same manner as if such coverage was a group health plan.

(5) OPT-OUT.—Nothing in this title shall be construed to require that an individual be enrolled in health insurance coverage.

(d) LIMITATION ON EXORBITANT PREMIUMS.—

(1) ESTABLISHMENT OF MECHANISM.—With respect to health insurance coverage offered through the State Exchange, the Exchange shall establish a mechanisms to protect enrollees from the imposition of excessive premiums, to reduce adverse selection, and to share risk.

(2) MECHANISM OPTIONS.—The mechanisms referred to in paragraph (1) may include the following:

(A) INDEPENDENT RISK ADJUSTMENT.—The implementation of risk-adjustment among health insurance coverage offered through the State Exchange through a contract entered into with a private, independent board. Such board shall include representation of health insurance issuers and State officials but shall be independently controlled. The State Exchange shall ensure that risk-adjustment implemented under this subparagraph shall be based on a blend of patient diagnoses and estimated costs.

(B) HEALTH SECURITY POOLS.—The establishment (or continued operation under section 2745 of the Public Health Service Act) of a health security pool to guarantee high-risk individuals access to affordable, quality health care.

(C) REINSURANCE.—The implementation of a successful reinsurance mechanisms to guarantee high-risk individuals access to affordable, quality health care.

(e) MEDICAID AND SCHIP BENEFICIARIES.—The State Exchange shall include procedures to permit eligible individuals who are receiving (or who are eligible to receive) health care under title XIX or XXI of the Social Security Act to enroll in health insurance coverage offered through the Exchange.

(f) DISSEMINATION OF COVERAGE INFORMATION.—The State Exchange shall ensure that each health insurance issuer that provides health insurance coverage through the Exchange disseminate to eligible individuals and employers within the State information concerning health insurance coverage options, including the plans offered and premiums and benefits for such plans.

(g) REGIONAL OPTIONS.—

(1) INTERSTATE COMPACTS.—Two or more States that establish a State Exchange may enter into interstate compacts providing for the regulations of health insurance coverage offered within such States.

(2) MODEL LEGISLATION.—States adopting model legislation as developed by the National Association of Insurance Commissioners shall be eligible to enter into an interstate compact as provided for in this section.

(3) MULTI-STATE POOLING ARRANGEMENTS.—State Exchanges may implement a multi-state health care coverage pooling arrangement under this title.

(h) PURCHASE ACROSS STATE LINES.—Notwithstanding any other provision of law, an eligible individual may enroll in health insurance coverage offered through the Exchange in any State. The regulation of such coverage (and the addressing of greviances relating to such coverage) shall be subject to the laws of the State in which such coverage is purchased, regardless of the State in which the eligible individual resides.

(i) ELIGIBLE INDIVIDUAL.—In this title, the term ''eligible individual'' means an individual who is—

(1) a citizen or national of the United States or an alien lawfully admitted to the United States for permanent residence or otherwise residing in the United States under color of law;

(2) not incarcerated; and

(3) not eligible for coverage under parts A and B (or C) of the Medicare program under title XVIII of the Social Security Act.

SEC. 203. STATE EXCHANGE INCENTIVES.

(a) GRANTS.—The Secretary may award grants, pursuant to subsection (b), to States for the development, implementation, and evaluation of certified State Exchanges and to provide more options and choice for individuals purchasing health insurance coverage.

(b) ONE-TIME INCREASE IN MEDICAID PAYMENT.—In the case of a State awarded a grant to carry out this section, the total amount of the Federal payment determined for the State under section 1913 of the Social Security Act (as amended by section 401) for fiscal year 2011 shall be increased by an amount equal to 1 percent of the total amount of payments made to the State for fiscal year 2010 under section 1903(a) of the Social Security Act (42 U.S.C. 1396b(a)) for purposes of carrying out a grant awarded under this section. Amounts paid to a State pursuant to this subsection shall remain available until expended.

TITLE III—FAIR TAX TREATMENT FOR ALL AMERICANS TO AFFORD HEALTH CARE

SEC. 300. REFERENCE.

Except as otherwise expressly provided, whenever in this title an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenue Code of 1986.

SEC. 301. REFUNDABLE AND ADVANCEABLE CREDIT FOR CERTAIN HEALTH INSURANCE COVERAGE.

(a) ADVANCEABLE CREDIT.—Subpart A of part IV of subchapter A of chapter 1 (relating to nonrefundable personal credits) is amended by adding at the end the following new section:

''SEC. 25E. QUALIFIED HEALTH INSURANCE CREDIT.

''(a) ALLOWANCE OF CREDIT.—In the case of an individual, there shall be allowed as a credit against the tax imposed by this chapter for the taxable year the sum of the monthly limitations determined under subsection (b) for the taxpayer and the taxpayer's spouse and dependents.

''(b) MONTHLY LIMITATION.—

''(1) IN GENERAL.—The monthly limitation for each month during the taxable year for an eligible individual is 1/12th of—

''(A) the applicable adult amount, in the case that the eligible individual is the taxpayer or the taxpayer's spouse,

''(B) the applicable adult amount, in the case that the eligible individual is an adult dependent, and

''(C) the applicable child amount, in the case that the eligible individual is a child dependent.

''(2) LIMITATION ON AGGREGATE AMOUNT.—Notwithstanding paragraph (1), the aggregate monthly limitations for the taxpayer and the taxpayer's spouse and dependents for any month shall not exceed 1/12th of the applicable aggregate amount.

''(3) NO CREDIT FOR INELIGIBLE MONTHS.—With respect to any individual, the monthly limitation shall be zero for any month for which such individual is not an eligible individual.

''(4) APPLICABLE AMOUNT.—

''(A) IN GENERAL.—For purposes of this section—

''(i) APPLICABLE ADULT AMOUNT.—The applicable adult amount is $2,290.

''(ii) APPLICABLE CHILD AMOUNT.—The applicable child amount is $1,710.

''(iii) APPLICABLE AGGREGATE AMOUNT.—The applicable aggregate amount is $5,710.

''(B) COST-OF-LIVING ADJUSTMENTS.—

''(i) IN GENERAL.—In the case of any taxable year beginning in a calendar year after 2011, each dollar amount contained in subparagraph (A) shall be increased by an amount equal to such dollar amount multiplied by the blended cost-of-living adjustment.

''(ii) BLENDED COST-OF-LIVING ADJUSTMENT.—For purposes of clause (i), the blended cost-of-living adjustment means one-half of the sum of—

''(I) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins by substituting 'calendar year 2010' for 'calendar year 1992' in subparagraph (B) thereof, plus

''(II) the cost-of-living adjustment determined under section 213(d)(10)(B)(ii) for the calendar year in which the taxable year begins by substituting '2010' for '1996' in subclause (II) thereof.

''(iii) ROUNDING.—Any increase determined under clause (i) shall be rounded to the nearest multiple of $10.

''(C) REVENUE NEUTRALITY ADJUSTMENTS.—

''(i) IN GENERAL.—In the case of any taxable year beginning in a calendar year after 2011, each dollar amount contained in subparagraph (A), as adjusted under subparagraph (B), shall be further adjusted (if necessary) such that the aggregate of such dollar amounts allowed as credits under this section for such taxable year equals but does not exceed the total increase in revenues in the Treasury resulting from the amendments made by sections 303 and 401 of the Patients' Choice Act for such taxable year as estimated by the Secretary.

''(ii) DATE OF ADJUSTMENT.—The Secretary shall announce the adjustments for any taxable year under this subparagraph not later than the preceding October 1.

''(c) LIMITATION BASED ON AMOUNT OF TAX.—In the case of a taxable year to which section 26(a)(2) does not apply, the credit allowed under subsection (a) for the taxable year shall not exceed the excess of—

''(1) the sum of the regular tax liability (as defined in section 26(b)) plus the tax imposed by section 55, over

''(2) the sum of the credits allowable under this subpart (other than this section) and section 27 for the taxable year.

''(d) EXCESS CREDIT REFUNDABLE TO CERTAIN TAX-FAVORED ACCOUNTS.—If—

''(1) the credit which would be allowable under subsection (a) if only qualified refund eligible health insurance were taken into account under this section, exceeds

''(2) the limitation imposed by section 26 or subsection (c) for the taxable year,

such excess shall be paid by the Secretary into the designated account of the taxpayer.

''(e) ELIGIBLE INDIVIDUAL.—For purposes of this section—

''(1) IN GENERAL.—The term 'eligible individual' means, with respect to any month, an individual who—

''(A) is the taxpayer, the taxpayer's spouse, or the taxpayer's dependent, and

''(B) is covered under qualified health insurance as of the 1st day of such month.

''(2) MEDICARE COVERAGE, MEDICAID DISABILITY COVERAGE, AND MILITARY COVERAGE.—The term 'eligible individual' shall not include any individual who for any month is—

''(A) entitled to benefits under part A of title XVIII of the Social Security Act or enrolled under part B of such title, and the individual is not a participant or beneficiary in a group health plan or large group health plan that is a primary plan (as defined in section 1862(b)(2)(A) of such Act),

''(B) enrolled by reason of disability in the program under title XIX of such Act, or

''(C) entitled to benefits under chapter 55 of title 10, United States Code, including under the TRICARE program (as defined in section 1072(7) of such title).

''(3) IDENTIFICATION REQUIREMENTS.—The term 'eligible individual' shall not include any individual for any month unless the policy number associated with the qualified health insurance and the TIN of each eligible individual covered under such health insurance for such month are included on the return of tax for the taxable year in which such month occurs.

''(4) PRISONERS.—The term 'eligible individual' shall not include any individual for a month if, as of the first day of such month, such individual is imprisoned under Federal, State, or local authority.

''(5) ALIENS.—The term 'eligible individual' shall not include any alien individual who is not a lawful permanent resident of the United States.

''(f) HEALTH INSURANCE.—For purposes of this section—

''(1) QUALIFIED HEALTH INSURANCE.—The term 'qualified health insurance' means any insurance constituting medical care which (as determined under regulations prescribed by the Secretary)—

''(A) has a reasonable annual and lifetime benefit maximum, and

''(B) provides coverage for inpatient and outpatient care, emergency benefits, and physician care.

Such term does not include any insurance substantially all of the coverage of which is coverage described in section 223(c)(1)(B).

''(2) QUALIFIED REFUND ELIGIBLE HEALTH INSURANCE.—The term 'qualified refund eligible health insurance' means any qualified health insurance which is coverage under a group health plan (as defined in section 5000(b)(1)).

''(g) DESIGNATED ACCOUNTS.—

''(1) DESIGNATED ACCOUNT.—For purposes of this section, the term 'designated account' means any specified account established and maintained by the provider of the taxpayer's qualified refund eligible health insurance—

''(A) which is designated by the taxpayer (in such form and manner as the Secretary may provide) on the return of tax for the taxable year,

''(B) which, under the terms of the account, accepts the payment described in subsection (d) on behalf of the taxpayer, and

''(C) which, under such terms, provides for the payment of expenses by the taxpayer or on behalf of such taxpayer by the trustee or custodian of such account, including payment to such provider.

''(2) SPECIFIED ACCOUNT.—For purposes of this paragraph, the term 'specified account' means—

''(A) any health savings account under section 223 or Archer MSA under section 220, or

''(B) any health insurance reserve account.

''(3) HEALTH INSURANCE RESERVE ACCOUNT.—For purposes of this subsection, the term 'health insurance reserve account' means a trust created or organized in the United States as a health insurance reserve account exclusively for the purpose of paying the qualified medical expenses (within the meaning of section 223(d)(2)) of the account beneficiary (as defined in section 223(d)(3)), but only if the written governing instrument creating the trust meets the requirements described in subparagraphs (B), (C), (D), and (E) of section 223(d)(1). Rules similar to the rules under subsections (g) and (h) of section 408 shall apply for purposes of this subparagraph.

''(4) TREATMENT OF PAYMENT.—Any payment under subsection (d) to a designated account shall not be taken into account with respect to any dollar limitation which applies with respect to contributions to such account (or to tax benefits with respect to such contributions).

''(h) OTHER DEFINITIONS.—For purposes of this section—

''(1) 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). An individual who is a child to whom section 152(e) applies shall be treated as a dependent of the custodial parent for a coverage month unless the custodial and noncustodial parent provide otherwise.

''(2) ADULT.—The term 'adult' means an individual who is not a child.

''(3) CHILD.—The term 'child' means a qualifying child (as defined in section 152(c)).

''(i) SPECIAL RULES.—

''(1) COORDINATION WITH MEDICAL DEDUCTION.—Any amount paid by a taxpayer for insurance which is taken into account for purposes of determining the credit allowable to the taxpayer under subsection (a) shall not be taken into account in computing the amount allowable to the taxpayer as a deduction under section 213(a) or 162(l).

''(2) COORDINATION WITH HEALTH CARE TAX CREDIT.—No credit shall be allowed under subsection (a) for any taxable year to any taxpayer and qualifying family members with respect to whom a credit under section 35 is allowed for such taxable year.

''(3) DENIAL OF CREDIT TO DEPENDENTS.—No credit shall be allowed under this section to any individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual's taxable year begins.

''(4) MARRIED COUPLES MUST FILE JOINT RETURN.—

''(A) IN GENERAL.—If the taxpayer is married at the close of the taxable year, the credit shall be allowed under subsection (a) only if the taxpayer and his spouse file a joint return for the taxable year.

''(B) MARITAL STATUS; CERTAIN MARRIED INDIVIDUALS LIVING APART.—Rules similar to the rules of paragraphs (3) and (4) of section 21(e) shall apply for purposes of this paragraph.

''(5) VERIFICATION OF COVERAGE, ETC.—No credit shall be allowed under this section with respect to any individual unless such individual's coverage (and such related information as the Secretary may require) is verified in such manner as the Secretary may prescribe.

''(6) INSURANCE WHICH COVERS OTHER INDIVIDUALS; TREATMENT OF PAYMENTS.—Rules similar to the rules of paragraphs (7) and (8) of section 35(g) shall apply for purposes of this section.

''(j) COORDINATION WITH ADVANCE PAYMENTS.—

''(1) REDUCTION IN CREDIT FOR ADVANCE PAYMENTS.—With respect to any taxable year, the amount which would (but for this subsection) be allowed as a credit to the taxpayer under subsection (a) shall be reduced (but not below zero) by the aggregate amount paid on behalf of such taxpayer under section 7527A for months beginning in such taxable year.

''(2) RECAPTURE OF EXCESS ADVANCE PAYMENTS.—If the aggregate amount paid on behalf of the taxpayer under section 7527A for months beginning in the taxable year exceeds the sum of the monthly limitations determined under subsection (b) for the taxpayer and the taxpayer's spouse and dependents for such months, then the tax imposed by this chapter for such taxable year shall be increased by the sum of—

''(A) such excess, plus

''(B) interest on such excess determined at the underpayment rate established under section 6621 for the period from the date of the payment under section 7527A to the date such excess is paid.

For purposes of subparagraph (B), an equal part of the aggregate amount of the excess shall be deemed to be attributable to payments made under section 7527A on the first day of each month beginning in such taxable year, unless the taxpayer establishes the date on which each such payment giving rise to such excess occurred, in which case subparagraph (B) shall be applied with respect to each date so established. The Secretary may rescind or waive all or any portion of

any amount imposed by reason of subparagraph (B) if such excess was not the result of the actions of the taxpayer.''.

(b) ADVANCE PAYMENT OF CREDIT.—Chapter 77 (relating to miscellaneous provisions) is amended by inserting after section 7527 the following new section:

''SEC. 7527A. ADVANCE PAYMENT OF CREDIT FOR QUALIFIED REFUND ELIGIBLE HEALTH INSURANCE.

''(a) IN GENERAL.—The Secretary shall establish a program for making payments on behalf of individuals to providers of qualified refund eligible health insurance (as defined in section 25E(f)(2)) for such individuals.

''(b) LIMITATION.—The Secretary may make payments under subsection (a) only to the extent that the Secretary determines that the amount of such payments made on behalf of any taxpayer for any month does not exceed the sum of the monthly limitations determined under section 25E(b) for the taxpayer and taxpayer's spouse and dependents for such month.''.

(c) INFORMATION REPORTING.—

(1) IN GENERAL.—Subpart B of part III of subchapter A of chapter 61 (relating to information concerning transactions with other persons) is amended by inserting after section 6050W the following new section:

''SEC. 6050X. RETURNS RELATING TO CREDIT FOR QUALIFIED REFUND ELIGIBLE HEALTH INSURANCE.

''(a) REQUIREMENT OF REPORTING.—Every person who is entitled to receive payments for any month of any calendar year under section 7527A (relating to advance payment of credit for qualified refund eligible health insurance) with respect to any individual shall, at such time as the Secretary may prescribe, make the return described in subsection (b) with respect to each such individual.

''(b) FORM AND MANNER OF RETURNS.—A return is described in this subsection if such return—

''(1) is in such form as the Secretary may prescribe, and

''(2) contains, with respect to each individual referred to in subsection (a)—

''(A) the name, address, and TIN of each such individual,

''(B) the months for which amounts payments under section 7527A were received,

''(C) the amount of each such payment,

''(D) the type of insurance coverage provided by such person with respect to such individual and the policy number associated with such coverage,

''(E) the name, address, and TIN of the spouse and each dependent covered under such coverage, and

''(F) such other information as the Secretary may prescribe.

''(c) STATEMENTS TO BE FURNISHED TO INDIVIDUALS WITH RESPECT TO WHOM INFORMATION IS REQUIRED.—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—

''(1) the contact information of the person required to make such return, and

''(2) the information required to be shown on the return with respect to such individual.

The written statement required under the preceding sentence shall be furnished on or before January 31 of the year following the calendar year for which the return under subsection (a) is required to be made.

''(d) RETURNS WHICH WOULD BE REQUIRED TO BE MADE BY 2 OR MORE PERSONS.—Except to the extent provided in regulations prescribed by the Secretary, in the case of any amount received by any person on behalf of another person, only the person first receiving such amount shall be required to make the return under subsection (a).''.

(2) ASSESSABLE PENALTIES.—

(A) Subparagraph (B) of section 6724(d)(1) (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 6050X (relating to returns relating to credit for qualified refund eligible health insurance), and''.

(B) Paragraph (2) of section 6724(d) 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 6050X (relating to returns relating to credit for qualified refund eligible health insurance).''.

(d) CONFORMING AMENDMENTS.—

(1) Paragraph (2) of section 1324(b) of title 31, United States Code, is amended by inserting ''25E,'' before ''35,''.

(2)(A) Section 24(b)(3)(B) is amended by inserting '', 25E,'' after ''25D''.

(B) Section 25(e)(1)(C)(ii) is amended by inserting ''25E,'' after ''25D,''.

(C) Section 25B(g)(2) is amended by inserting ''25E,'' after ''25D,''.

(D) Section 26(a)(1) is amended by inserting ''25E,'' after ''25D,''.

(E) Section 30(c)(2)(B)(ii) is amended by inserting ''25E,'' after ''25D,''.

(F) Section 30D(c)(2)(B)(ii) is amended by striking ''and 25D'' and inserting '', 25D, and 25E''.

(G) Section 904(i) is amended by inserting ''25E,'' after ''25B,''.

(H) Section 1400C(d)(2) is amended by inserting ''25E,'' after ''25D,''.

(3) The table of sections for subpart A of part IV of subchapter A of chapter 1 is amended by inserting after the item relating to section 25D the following new item:

''Sec. 25E. Qualified health insurance credit.''.

(4) The table of sections for chapter 77 is amended by inserting after the item relating to section 7527 the following new item:

''Sec. 7527A. Advance payment of credit for qualified refund eligible health insurance.''.

(5) The table of sections for subpart B of part III of subchapter A of chapter 61 is amended by adding at the end the following new item:

''Sec. 6050X. Returns relating to credit for qualified refund eligible health insurance.''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2010.

SEC. 302. REQUIRING EMPLOYER TRANSPARENCY ABOUT EMPLOYEE BENEFITS.

(a) IN GENERAL.—Section 6051(a) (relating to W–2 requirement) 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 inserting after paragraph (13) the following new paragraph:

''(14) the aggregate cost (within the meaning of section 4980B(f)(4)) for coverage of the employee under an accident or health plan which is excludable from the gross income of the employee under section 106(a) (other than coverage under a health flexible spending arrangement).''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to statements for calendar years beginning after 2009.

SEC. 303. CHANGES TO EXISTING TAX PREFERENCES FOR MEDICAL COVERAGE, ETC., FOR INDIVIDUALS ELIGIBLE FOR QUALIFIED HEALTH INSURANCE CREDIT.

(a) EXCLUSION FOR CONTRIBUTIONS BY EMPLOYER TO ACCIDENT AND HEALTH PLANS.—

(1) IN GENERAL.—Section 106 (relating to contributions by employer to accident and health plans) is amended by adding at the end the following new subsection:

''(f) NO EXCLUSION FOR INDIVIDUALS ELIGIBLE FOR QUALIFIED HEALTH INSURANCE CREDIT.—Subsection (a) shall not apply with respect to any employer-provided coverage under an accident or health plan for any individual for any month unless such individual is described in paragraph (2) or (5) of section 25E(e) for such month. The amount includible in gross income by reason of this subsection shall be determined under rules similar to the rules of section 4980B(f)(4).''.

(2) CONFORMING AMENDMENTS.—

(A) Section 106(b)(1) is amended—

(i) by inserting ''gross income does not include'' before ''amounts contributed'', and

(ii) by striking ''shall be treated as employer-provided coverage for medical expenses under an accident or health plan''.

(B) Section 106(d)(1) is amended—

(i) by inserting ''gross income does not include'' before ''amounts contributed'', and

(ii) by striking ''shall be treated as employer-provided coverage for medical expenses under an accident or health plan''.

(b) AMOUNTS RECEIVED UNDER ACCIDENT AND HEALTH PLANS.—Section 105 (relating to amounts received under accident and health plans) is amended by adding at the end the following new subsection:

''(f) NO EXCLUSION FOR INDIVIDUALS ELIGIBLE FOR QUALIFIED HEALTH INSURANCE CREDIT.—Subsection (b) shall not apply with respect to any employer-provided coverage under an accident or health plan for any individual for any month unless such individual is described in paragraph (2) or (5) of section 25E(e) for such month.''.

(c) SPECIAL RULES FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.—Subsection (l) of section 162 (relating to special rules for health insurance costs of self-employed individuals) is amended by adding at the end the following new paragraph:

''(6) NO DEDUCTION TO INDIVIDUALS ELIGIBLE FOR QUALIFIED HEALTH INSURANCE.—Paragraph (1) shall not apply for any individual for any month unless such individual is described in paragraph (2) or (5) of section 25E(e) for such month.''.

(d) EARNED INCOME CREDIT UNAFFECTED BY REPEALED EXCLUSIONS.—Subparagraph (B) of section 32(c)(2) is amended by redesignating clauses (v) and (vi) as clauses (vi) and (vii), respectively, and by inserting after clause (iv) the following new clause:

''(v) the earned income of an individual shall be computed without regard to sections 105(f) and 106(f),''.

(e) MODIFICATION OF DEDUCTION FOR MEDICAL EXPENSES.—Subsection (d) of section 213 is amended by adding at the end the following new paragraph:

''(12) PREMIUMS FOR QUALIFIED HEALTH INSURANCE.—The term 'medical care' does not include any amount paid as a premium for coverage of an eligible individual (as defined in section 25E(e)) under qualified health insurance (as defined in section 25E(f)) for any month.''.

(f) REPORTING REQUIREMENT.—Subsection (a) of section 6051 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 inserting after paragraph (13) the following new paragraph:

''(14) the total amount of employer-provided coverage under an accident or health plan which is includible in gross income by reason of sections 105(f) and 106(f).''.

(g) RETIRED PUBLIC SAFETY OFFICERS.—Section 402(l)(4)(D) is amended by adding at the end the following: ''Such term shall not include any premium for coverage by an accident or health insurance plan for any

month unless such individual is described in paragraph (2) or (5) of section 25E(e) for such month.''.

(h) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2010.

(i) NO INTENT TO ENCOURAGE STATE TAXATION OF HEALTH BENEFITS.—No intent to encourage any State to treat health benefits as taxable income for the purpose of increasing State income taxes may be inferred from the provisions of, and amendments made by, this section.

SEC. 304. DETERMINATION OF ELIGIBILITY.

(a) APPLICATION OF INCOME AND ELIGIBILITY VERIFICATION SYSTEM (IEVS) AND THE SYSTEMATIC ALIEN VERIFICATION FOR ENTITLEMENTS (SAVE) PROGRAMS.—In order to obtain coverage through an Exchange, an individual must have had his or her eligibility determined and approved under the Income and Eligibility Verification System (IEVS) and the Systematic Alien Verification for Entitlements (SAVE) programs under section 1137 of the Social Security Act. The benefit determination and approval under this subsection shall be the responsibility of the Exchange-participating health plans involved.

(b) CREDITS.—In addition to satisfying the eligibility requirements specified in subsection (a), to be considered a credit eligible individual under the amendments made by this title, an individual must have had his or her eligibility for the credit determined and approved under the Income and Eligibility Verification System (IEVS) and the Systematic Alien Verification for Entitlements (SAVE) programs under section 1137 of the Social Security Act. The benefit determination and approval under this subsection shall be the responsibility of the Exchange-participating health plans in which the individual enrolls and attempts to utilize the credit.

(c) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2009.

SEC. 305. ADJUSTMENTS.

Notwithstanding any other provision of law, the Secretary of the Treasury shall adjust the growth of tax credits provided for under this amendments made by this title at such levels as appropriate so that this Act will remain budget neutral.

TITLE IV—FAIRNESS FOR EVERY AMERICAN PATIENT

Subtitle A—Medicaid Modernization

SEC. 401. MEDICAID MODERNIZATION.

(a) IN GENERAL.—Effective January 1, 2011, title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended to read as follows:

"TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

''TABLE OF CONTENTS OF TITLE

''Sec. 1900. References to pre-modernized Medicaid provisions; continuity for commonwealths and territories.

''PART A—GRANTS TO STATES FOR ACUTE CARE FOR INDIVIDUALS WITH DISABILITIES AND CERTAIN LOW-INCOME INDIVIDUALS

''Sec. 1901. Purpose; Appropriation.
''Sec. 1902. Payments to States for acute care medical assistance.
''Sec. 1903. Definitions of eligible individuals and acute care medical assistance.
''Sec. 1904. State plan requirements for acute care medical assistance.
''Sec. 1905. Definitions.
''Sec. 1906. Enrollment of individuals under group health plans and other arrangements.
''Sec. 1907. Drug rebates.
''Sec. 1908. Managed care.
''Sec. 1909. Annual reports.

''PART B—GRANTS TO STATES FOR LONG-TERM CARE SERVICES AND SUPPORTS

''Sec. 1911. Purpose.
''Sec. 1912. State plan.
''Sec. 1913. State allotments.
''Sec. 1914. Use of grants.
''Sec. 1915. Administrative provisions.
''Sec. 1916. Definition of long-term care services and supports.
''Sec. 1917. Provision requirements for long-term care services and supports, including option for self-directed services and supports.
''Sec. 1918. Treatment of income and resources for certain institutionalized spouses.
''Sec. 1919. Annual reports.

''PART C—GRANTS TO STATES FOR SURVEY AND CERTIFICATION OF MEDICAL FACILITIES AND OTHER REQUIREMENTS

''Sec. 1931. Authorization of appropriations.
''Sec. 1932. Application of certain requirements under pre-modernized Medicaid.

''PART D—GRANTS TO STATES FOR PROGRAM INTEGRITY

''Sec. 1941. Authorization of appropriations.
''Sec. 1942. Application of certain requirements under pre-modernized Medicaid.

''PART E—GRANTS TO STATES FOR ADMINISTRATION

''Sec. 1951. Authorization of appropriations; payments to states.
''Sec. 1952. Cost-sharing protections.
''Sec. 1953. Application of certain requirements under pre-modernized Medicaid.

''PART F—OTHER PROVISIONS

''Sec. 1961. Application of certain requirements under pre-modernized Medicaid.

"SEC. 1900. REFERENCES TO PRE-MODERNIZED MEDICAID PROVISIONS; CONTINUITY FOR COMMONWEALTHS AND TERRITORIES.

''(a) IN GENERAL.—In this title, if a reference to this title or to a provision of this title is prefaced by the term 'old', such reference is to this title or a provision of this title as in effect on December 31, 2010.

''(b) REGULATIONS.—The Secretary shall promulgate regulations to bring requirements imposed under an old provision of this title that applies under this title after December 31, 2010, into conformity with the policies embodied in this title as in effect on and after January 1, 2011.

''(c) CONTINUITY FOR COMMONWEALTHS AND TERRITORIES.—In the case of Puerto Rico, the United States Virgin Islands, Guam, the Northen Mariana Islands, and American Samoa, this title as in effect on and after January 1, 2011, shall not apply to such commonwealths and territories, and old title XIX shall apply to a Medicaid program operated by such commonwealths or territories on and after that date.

"PART A—GRANTS TO STATES FOR ACUTE CARE FOR INDIVIDUALS WITH DISABILITIES AND CERTAIN LOW-INCOME INDIVIDUALS

"SEC. 1901. PURPOSE; APPROPRIATION.

''(a) PURPOSE.—It is the purpose of this part to enable each State, as far as practicable under the conditions in the State, to provide acute care medical assistance to eligible individuals described in section 1903 whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such individuals attain or retain capability for independence or self-care.

''(b) APPROPRIATION.—For the purpose of making payments to States under this part, there is appropriated out of any money in the Treasury not otherwise appropriated, such sums as are necessary for fiscal year 2011 and each fiscal year thereafter.

"SEC. 1902. PAYMENTS TO STATES FOR ACUTE CARE MEDICAL ASSISTANCE.

''(a) IN GENERAL.—From the amounts appropriated under section 1901 for a fiscal year, the Secretary shall pay to each State which has a plan approved under this part, for each quarter, beginning with the quarter commencing January 1, 2011, an amount equal to the Federal medical assistance percentage (as defined in section 1905(b)) of the total amount expended during such quarter as acute care medical assistance under the State plan under this part.

''(b) ADMINISTRATIVE EXPENSES.—Each State with a plan approved under this part shall receive a payment determined in accordance with part E for administrative expenses incurred in carrying out the plan under this part and part B (if the State has a plan approved under that part).

"SEC. 1903. DEFINITIONS OF ELIGIBLE INDIVIDUALS AND ACUTE CARE MEDICAL ASSISTANCE.

''(a) ELIGIBLE INDIVIDUALS.—

''(1) IN GENERAL.—In this part, the term 'eligible individual' means an individual—

''(A) who is—

''(i) a blind or disabled individual; or

''(ii) an individual described in paragraph (2); and

''(B) who the State determines satisfies—

''(i) the income and resources eligibility requirements established by the State under the State plan under this part; and

''(ii) such other requirements for assistance as are imposed under this title, including documentation of citizenship or status as a qualified alien under title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

''(2) INDIVIDUALS DESCRIBED.—For purposes of paragraph (1)(A)(ii), the following individuals are described in this paragraph:

''(A) A child in foster care under the responsibility of the State.

''(B) A low-income woman with breast or cervical cancer described in old section 1902(aa).

''(C) Certain TB-infected individuals described in old section 1902(z)(1).

''(3) GRANDFATHERED INDIVIDUALS.—An individual shall be an eligible individual under the State plan under this part if—

''(A) the individual is described in paragraph (1)(A);

''(B) the individual satisfies the documentation requirements referred to in paragraph (1)(B)(ii); and

''(C) the State would have provided medical assistance under the State plan under old title XIX to the individual, but only so long as the individual continues to satisfy such old eligibility requirements.

''(4) CONCURRENT ELIGIBILITY FOR PART B.—An eligible individual under this part may be eligible under part B, but only if the individual satisfies the eligibility requirements of part B in addition to satisfying the requirements for eligibility under this part.

''(5) PRESUMPTIVE ELIGIBILITY FOR CERTAIN BREAST OR CERVICAL CANCER PATIENTS.—Old section 1920B (relating to presumptive eligibility for certain breast or cervical cancer patients) shall apply under this part.

''(b) BENEFITS.—Subject to paragraph (3), in this part, the term 'acute care medical assistance' means the following:

''(1) MANDATORY BENEFITS.—The care and services listed in paragraphs (1) through (5), (17), and (21) of old section 1905(a) (but, in the case of paragraph (4)(A) of such section, without regard to any limitation based on

age or services in an institution for mental diseases).

''(2) OPTIONAL BENEFITS.—Any care or services listed in a paragraph of old section 1905(a) (other than paragraph (16)).

''(3) EXCEPTIONS.—

''(A) CERTAIN SERVICES LIMITED TO PART B.—Services described in paragraphs (15), (22), (23), (24), and (26) of old section 1905(a) shall only be provided under the State plan under part B.

''(B) LIMIT ON PROVISION OF LONG-TERM CARE SERVICES AND SUPPORTS.—A care or service that the Secretary determines is a long-term care service and support (including nursing facility services described in old section 1905(a)(4)(A)) shall not be provided to an individual under the State plan under this part for more than 30 days within any 12-month period.

''(C) EXCLUSIONS.—Such term shall not include any payments with respect to care or services for any individual who is an inmate of a public institution or a patient in an institution for mental diseases (regardless of age).

''SEC. 1904. STATE PLAN REQUIREMENTS FOR ACUTE CARE MEDICAL ASSISTANCE.

''(a) IN GENERAL.—In order to receive payments under this part, a State shall have an approved State plan for acute care medical assistance. For purposes of this part, such assistance includes payments for preventive care, primary care, diagnosis and treatment of acute and chronic health conditions, emergency care, diagnosis and treatment of mental illnesses and related conditions, and rehabilitation and other services to help eligible individuals attain or retain capability for independence or self-care. A State medical assistance plan shall include a description, consistent with the requirements of this part of—

''(1) eligibility standards, including income and asset standards;

''(2) benefits, including the amount, duration, and scope of covered items and services;

''(3) strategies for improving access and quality of care; and

''(4) methods of service delivery.

''(b) PUBLIC AVAILABILITY OF STATE PLAN.—The State shall make available to the public the State plan under this part and any amendments submitted by the State to the plan.

''(c) AMOUNT, DURATION, AND SCOPE.—The State plan shall provide that the acute care medical assistance made available to any eligible individual shall not be less in amount, duration, or scope than the acute care medical assistance made available to any other eligible individual.

''(d) APPLICATION OF CERTAIN PRE-MODERNIZED MEDICAID REQUIREMENTS.—

''(1) OLD STATE PLAN REQUIREMENTS.—The following provisions of old section 1902 shall apply to the State plans under this part:

''(A) Old section 1902(a)(10)(C) (relating to certain eligibility and other requirements).

''(B) Old section 1902(a)(10)(D) (relating to home health services).

''(C) Old section 1902(a)(10)(G) (relating to nonapplication of certain supplemental security income eligibility criteria).

''(D) The subclauses in the flush matter following old section 1902(a)(10)(G) (relating to the provision of certain services) other than subclauses (V), (VII), (VIII), and (IX).

''(E) Old section 1902(a)(17) (relating to reasonable standards for determining eligibility).

''(F) Old section 1902(a)(19) (relating to eligibility safeguards).

''(G) Old section 1902(a)(34) (relating to eligibility beginning with the third month prior to the month of application).

''(H) Subparagraphs (A), (B), and (C) of old section 1902(a)(43) (relating to early and periodic screening, diagnostic, and treatment services).

''(I) Old section 1902(a)(46)(A) (relating to compliance with section 1137 requirements).

''(J) The fourth and sixth sentences of old section 1902(a) (relating to eligibility for certain individuals).

''(2) OTHER OLD TITLE XIX REQUIREMENTS.—

''(A) Old section 1902(e)(3) (relating to optional eligibility for certain disabled individuals).

''(B) Old section 1902(e)(9) (relating to optional respiratory care services).

''(C) Old section 1902(f) (relating to eligibility of certain aged, blind, or disabled individuals).

''(D) Old section 1902(m) (relating to eligibility of certain aged or disabled individuals), other than paragraph (4).

''(E) Old section 1902(o) (relating to disregard of certain supplemental security income benefits).

''(F) Old section 1902(v) (relating to eligibility determinations of blind or disabled individuals).

''(e) OTHER REQUIREMENTS.—The State plan under this part shall—

''(1) comply with the requirements of the other parts of this title; and

''(2) provide that the State will make the contributions specified under section 340A–1(e) of the Public Health Service Act .

''SEC. 1905. DEFINITIONS.

''(a) IN GENERAL.—The definitions specified in this section shall apply for purposes of this part and, to the extent applicable and consistent with the policy embodied in such part, parts B, C, D, E, and F.

''(b) FEDERAL MEDICAL ASSISTANCE PERCENTAGE.—The term 'Federal medical assistance percentage' for any State shall be 100 percent less the State percentage; and the State percentage shall be that percentage which bears the same ratio to 45 percent as the square of the per capita income of such State bears to the square of the per capita income of the continental United States (including Alaska) and Hawaii, except that the Federal medical assistance percentage shall in no case be less than 50 percent or more than 83 percent. The Federal medical assistance percentage for any State shall be determined and promulgated in accordance with the provisions of section 1101(a)(8)(B).

''(c) APPLICATION OF CERTAIN PRE-MODERNIZED MEDICAID PROVISIONS.—The following old provisions shall apply under this part:

''(1) OLD SECTION 1905 PROVISIONS.—The following provisions of old section 1905:

''(A) Old section 1905(d) (relating to the definition of an intermediate care facility for the mentally retarded).

''(B) Old section 1905(e) (relating to the definition of physicians services).

''(C) Old section 1905(f) (relating to the definition of nursing facility services).

''(D) Old section 1905(g) (relating to the provision of chiropractors' services).

''(E) Old section 1905(j) (relating to State supplementary payments).

''(F) Old section 1905(k) (relating to supplemental security income benefits payable pursuant to section 211 of Public Law 93–66).

''(G) Old section 1905(l)(1) (relating to rural health clinic services).

''(H) Old section 1905(o) (relating to hospice care).

''(I) Old section 1905(q) (relating to the definition of a qualified severely impaired individual).

''(J) Old section 1905(r) (relating to the definition of early and periodic screening, diagnostic, and treatment services).

''(K) Old section 1905(s) (relating to the definition of a qualified disabled and working individual).

''(L) Old section 1905(t) (relating to the definition of primary care case management services).

''(M) Old section 1905(v) (relating to the definition of an employed individual with a medically improved disability).

''(N) Paragraphs (1) and (3) of old section 1905(w) (relating to the definition of an independent foster care adolescent).

''(O) Old section 1905(x) (relating to strategies, treatment, and services for individuals with Sickle Cell Disease).

''(2) OTHER OLD PROVISIONS.—

''(A) Old section 1903(m) (relating to the definition of a medicaid managed care organization).

''SEC. 1906. ENROLLMENT OF INDIVIDUALS UNDER GROUP HEALTH PLANS AND OTHER ARRANGEMENTS.

''The following old provisions shall apply under this part:

''(1) Old section 1906 (relating to enrollment of individuals under group health plans).

''(2) Old section 1902(a)(70) (relating to State option to establish a non-emergency medical transportation brokerage program).

''(3) Paragraphs (2) and (11) of old section 1902(e) (relating to eligibility for individuals enrolled with a group health plan or under a managed care arrangement during a minimum enrollment period).

''SEC. 1907. DRUG REBATES.

''Old sections 1902(a)(54) and 1927 (relating to payment for covered outpatient drugs and rebates) shall apply under this part.

''SEC. 1908. MANAGED CARE.

''The following old provisions shall apply under this part:

''(1) Old section 1932 (relating to managed care), other than subsection (a)(2) of such section.

''(2) Old section 1903(k) (relating to technical and actuarial assistance for States).

''SEC. 1909. ANNUAL REPORTS.

''(a) IN GENERAL.—Each State that receives payments under this part shall submit an annual report to the Secretary, in such form and manner as the Secretary shall specify.

''(b) APPLICATION OF OLD EPSDT REPORTING REQUIREMENTS.—Each annual report shall include the information required to be reported under old section 1902(a)(43)(D)(iv).

''PART B—GRANTS TO STATES FOR LONG-TERM CARE SERVICES AND SUPPORTS

''SEC. 1911. PURPOSE.

''(a) IN GENERAL.—The purpose of this part is to increase the flexibility of States in operating a system of long-term care services and supports designed to—

''(1) provide assistance to needy families so that individuals with disabilities and low-income senior citizens may be served and supported in their own homes and communities;

''(2) emphasize the independence and dignity of the person served by public programs;

''(3) end the institutional bias that existed under the Medicaid program prior to January 1, 2011;

''(4) provide stable and predictable funding for States as they rebalance their long-term care systems from institutions to communities;

''(5) provide flexibility to States to adopt new and innovative service delivery methods; and

''(6) promote independence and support activities that will enable individuals to return or maintain ties to the community, including through employment.

''(b) NO INDIVIDUAL ENTITLEMENT.—No individual determined eligible for long-term care services and supports under this part shall be entitled to a specific service or type of delivery of service.

''SEC. 1912. STATE PLAN.

''(a) IN GENERAL.—In order to receive payments under this part, a State must have an

approved State plan for long-term care services and supports. A State long term care services and supports plan shall include a description, consistent with the requirements of this part, of—

''(1) income and assets eligibility standards and spousal impoverishment protections consistent with subsection (b);

''(2) the standardized assessments tools used to determine eligibility for specific long-term care services and supports;

''(3) the person-centered plans used to provide such services and supports;

''(4) the proposed uses of funding, if applicable, to provide targeted methods to meet individual level of support needs including tiering (preventive, emergency, low, medium, high); and

''(5) the long-term care services and supports to be available under the plan based on individual assessment of need in accordance with sections 1916 and 1917.

''(b) MINIMUM ELIGIBILITY STANDARDS.—

''(1) POPULATIONS COVERED.—The State plan shall specify the disabled and elderly populations who are eligible for long-term care services and supports.

''(2) NEEDS-BASED CRITERIA.—The plan shall include a description of the needs-based criteria the State will use to assess an individual's need for specific services and supports available under the State plan.

''(3) OTHER ELIGIBILITY REQUIREMENTS.—

''(A) INCOME AND ASSETS.—A State may use different income and asset standards and methodologies for determining eligibility than those used for determining eligibility for acute care medical assistance under part A. A State may not make eligibility standards related to income, asset, and spousal impoverishment protection more restrictive than the Federal minimum requirements of December 31, 2008.

''(B) APPLICATION OF SPOUSAL IMPOVERISHMENT PROTECTIONS.—The State plan shall provide that the State shall comply with the requirements of section 1918 (relating to spousal impoverishment protections).

''(C) STATEWIDENESS.—The State plan shall provide that, except with respect to methods used for determining homestead exemptions, the income and asset standards and methodologies shall be in effect in all political subdivisions of the State.

''(4) TRANSITION ASSISTANCE.—The State plan shall specify how the State will provide transition assistance for individuals who, on December 31, 2010, are enrolled under the State plan under old title XIX (or under a waiver of that plan) and receiving long-term care services or supports on that date. The State shall provide such assistance to individuals who are and are not likely to be determined eligible for long-term care services and supports under the State plan under this part, as in effect on January 1, 2011 (or the first day on which the State plan is in effect under this part).

''(c) PAYMENT METHODOLOGIES TO PROVIDERS.—

''(1) IN GENERAL.—The State plan shall describe the methodologies used to determine payments to providers. Such methodologies—

''(A) may be varied to assist in transitioning from facilities-based to community-based care; and

''(B) shall not be subject to Secretarial approval.

''(2) TRANSPARENCY.—The State plan shall provide that the State shall make publicly available—

''(A) the payment methodologies applicable under the plan; and

''(B) the name of any provider that receives $1,000,000 or more in any 12-month period and the actual amount paid to the provider during that period.

''(d) COORDINATION OF EFFORT WITH OTHER RELATED PUBLIC AND PRIVATE PROGRAMS.—The plan shall include a description of the State's efforts to coordinate the delivery of services and supports under the plan with other related public and private programs that serve individuals with disabilities or aged populations that need or may be at risk of needing long term care.

''(e) PUBLIC AVAILABILITY OF STATE PLAN.—The State shall make available to the public the State plan under this part and any amendments submitted by the State to the plan.

''(f) APPLICATION OF OLD TITLE XIX REQUIREMENTS.—The following old title XIX provisions shall apply to a State plan under this part:

''(1) Subsections (a)(50) and (q) of old section 1902 (relating to a monthly personal needs allowance for certain institutionalized individuals and couples).

''(2) Old section 1902(a)(67) (relating to payment for certain services furnished to a PACE program eligible individual).

''(3) Paragraph (1) of old section 1902(r) (relating to the post-eligibility treatment of income for certain individuals) and paragraph (2) of such section (relating to methodologies for determining income and resource eligibility for individuals, but only with respect to individuals who are eligible under this part on or after January 1, 2011).

''(4) Old section 1905(i) (relating to the definition of an institution for mental diseases).

''(g) OTHER REQUIREMENTS OF OTHER PARTS.—The State plan under this part shall—

''(1) comply with the requirements of the other parts of this title; and

''(2) provide that the State will make the contributions specified under section 340A–1(e) of the Public Health Service Act.

''SEC. 1913. STATE ALLOTMENTS.

''(a) APPROPRIATION.—For the purpose of providing allotments to States under this section, there is appropriated out of any money in the Treasury not otherwise appropriated—

''(1) for fiscal year 2011, $65,274,560,000;

''(2) for fiscal year 2012, $67,885,540,000;

''(3) for fiscal year 2013, $70,600,964,100;

''(4) for fiscal year 2014, $73,425,000,000;

''(5) for fiscal year 2015, $76,362,000,000;

''(6) for fiscal year 2016, $79,416,480,000;

''(7) for fiscal year 2017, $82,593,140,000;

''(8) for fiscal year 2018, $85,896,870,000; and

''(9) for fiscal year 2019, $89,332,743,000.

''(b) ALLOTMENTS TO 50 STATES AND THE DISTRICT OF COLUMBIA.—

''(1) FISCAL YEAR 2011 ALLOTMENTS.—Subject to subsection (e), the Secretary shall allot to each State with a long term care plan approved under this title an amount in fiscal year 2011 equal to the Federal expenditures made by the State for long-term care as defined in section 1916 in fiscal year 2008, increased by 8 percent.

''(2) SUBSEQUENT FISCAL YEAR ALLOTMENTS.—For fiscal year 2012 and each subsequent fiscal year through fiscal year 2019, the allotment for a State under this section is equal to the allotment for the State determined for the preceding fiscal year, increased by 4 percent.

''(c) LIMITATION.—

''(1) IN GENERAL.—Except as provided in paragraph (2), no other Federal funds are available under this title for expenditures incurred for long-term care services and supports after December 31, 2010, except as provided under a State plan approved under this part.

''(2) EXCEPTION.—

''(A) IN GENERAL.—If a State does not have an approved State plan by October 1, 2010, the Secretary may make payments equal to 85 percent of the State's estimated quarterly allotment until June 30, 2011.

''(B) FULL FUNDING.—A State shall receive 100 percent of its allotment for fiscal year 2011 if the State has a plan approved under this part by June 30, 2011.

''(d) MAINTENANCE OF EFFORT.—In order to qualify for the grant payable under this section, the State must demonstrate in each fiscal year that it made long-term care service and supports expenditures (including funding from local government sources) equal to the amount of not less than 95 percent of the nonfederal share amount spent in fiscal year 2009 under the State plan under old title XIX on long term care services and supports (as defined in section 1916). Expenditures not made under this part shall not be recognized by the Secretary for purposes of this requirement.

''(e) GRANTS REDUCED IF INSUFFICIENT APPROPRIATIONS.—

''(1) IN GENERAL.—If the amount appropriated for fiscal year 2011 under subsection (a)(1) is less than the amount necessary to fund each State's allotment for that fiscal year, the Secretary shall reduce the allotment for each State for that fiscal year based on the applicable percentage determined for the State under paragraph (2).

''(2) APPLICABLE PERCENTAGE.—For purposes of paragraph (1), the applicable percentage determined with respect to a State is as follows:

''If the ratio of the State's non-institutional spending to total long-term care spending for fiscal year 2009 is:	**The applicable percentage is:**
50 percent or greater	100
at least 46, but less than 50 percent	99
at least 40, but less than 46 percent	98
at least 36, but less than 40	97
at least 30, but less than 36	96
less than 30 percent	95.

''(f) ADMINISTRATIVE EXPENSES.—

''(1) IN GENERAL.—Each State with a plan approved under this part shall receive a payment determined in accordance with amounts appropriated for part E for administrative expenses incurred in carrying out the plan under this part and part A.

''(2) ASSESSMENT-RELATED COSTS.—Costs attributable to providing an individualized needs-based assessment for purposes of identifying the long-term care services and supports to be provided under the State plan to an individual shall be considered a long-term care service and support and shall not be treated as an administrative expense.

"SEC. 1914. USE OF GRANTS.

''(a) IN GENERAL.—A State shall use funds for long-term care services and supports as defined in section 1916.

''(b) SELF-DIRECTION.—A State shall offer individuals the opportunity to self-direct their long-term care services and supports.

"SEC. 1915. ADMINISTRATIVE PROVISIONS.

''(a) FUNDING ON A QUARTERLY BASIS.—The Secretary shall make payments to States in equal amounts of a State's annual allotment on a quarterly basis. Each quarterly payment shall remain available for use by the State for twelve succeeding fiscal year quarters.

''(b) PUBLICATION.—The Secretary shall publish each State's allotment—

''(1) for fiscal year 2011 not later than December 15, 2009; and

''(2) for each subsequent fiscal year, not later than December 15 of the calendar year preceding the calendar year in which the fiscal year begins.

"SEC. 1916. DEFINITION OF LONG-TERM CARE SERVICES AND SUPPORTS.

''(a) DEFINITION.—

''(1) IN GENERAL.—Subject to subsection (e), in this part, the term 'long-term care services and supports' means any of the services or supports specified in paragraphs (2) or (3) that may be provided in a nursing facility, an institution, a home, or other setting.

''(2) SERVICES AND SUPPORTS DESCRIBED.—For purposes of paragraph (1), the services and supports described in this paragraph include assistive technology, adaptive equipment, remote monitoring equipment, case management for the aged, case management for individuals with disabilities, nursing home services, long-term rehabilitative services necessary to restore functional abilities, services provided in intermediate care facilities for people with disabilities, habilitation services (including adult day care programs), community treatment teams for individuals with mental illness, home health services, services provided in an institution for mental disease, a Program of All-Inclusive Care for the Elderly (PACE), personal care (including personal assistance services), recovery support including peer counseling, supportive employment, training skills necessary to assist the individual in achieving or maintaining independence, training of family members including foster parents in supportive and behavioral modification skills, ongoing and periodic training to maintain life skills, transitional care including room and board not to exceed 60 days within a 12-month period.

''(3) INCLUSION OF CERTAIN BENEFITS UNDER OLD TITLE XIX.—Such services and supports may include any of the following services:

''(A) Old section 1905(a)(15) (relating to services in an intermediate care facility for the mentally retarded).

''(B) Services described in subsections (a)(16) and (h) of old section 1905, but without regard to any restriction on such services on the basis of age (relating to inpatient psychiatric hospital services).

''(C) Old section 1905(a)(22) (relating to home and community care (to the extent allowed and as defined in old section 1929) for functionally disabled elderly individuals).

''(D) Old section 1905(a)(23) (relating to community supported living arrangements services (to the extent allowed and as defined in old section 1930)).

''(E) Subject to subsection (e), old section 1905(a)(24) but without regard to any restriction on furnishing services to patients or residents of facilities or institutions (relating to personal care services).

''(F) Old sections 1905(a)(26) and 1934 (relating to services furnished under a PACE program under old section 1934 to PACE program eligible individuals enrolled under the program under such old section).

''(G) Old section 1915(c)(5) (relating to the definition of habilitation services).

''(4) LIMITATION.—Long-term care services and supports cannot be used for services and administrative costs provided through the foster care (with the exception of training of foster care parents), child welfare, adult protective services, juvenile justice, public guardianship, or correctional systems.

''(b) REHABILITATIVE CARE.—For purposes of rehabilitation due to acute care medical needs, a State may claim rehabilitative services provided in an institutional setting, nursing home, or as part of home health expenditures as acute care benefits under the State plan under part A rather than under the State plan under this part for a cumulative period of 30 days within a 12-month period if such care is directly related to the onset of an acute care need. A State shall demonstrate the services were provided as a direct result of an acute care need.

''(c) MANAGED CARE.—If a State provides long-term care services and supports through managed care, the State shall submit a methodology for determining the level of expenditures attributed to long term care for approval by the Secretary.

''(d) APPLICATION OF PART A DEFINITIONS.—A definition specified in section 1905 shall apply to the same term used in this part, unless the Secretary determines that the application of such definition would be inconsistent with the purpose of this part.

''(e) EXCLUSION.—No payments shall be made under the State plan under this part with respect to long-term care supports and services provided for any individual who is an inmate of a public institution. Nothing in the preceding sentence shall be construed as precluding the provision of long-term care services and supports under the State plan under this part to an individual who is a patient in an institution for mental diseases.

"SEC. 1917. PROVISION REQUIREMENTS FOR LONG-TERM CARE SERVICES AND SUPPORT, INCLUDING OPTION FOR SELF-DIRECTED SERVICES AND SUPPORTS.

''(a) REQUIREMENTS FOR THE PROVISION OF LONG-TERM CARE SERVICES AND SUPPORTS.—

''(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, a State may provide through a State plan amendment for the provision of long-term care services and supports for individuals eligible under the State plan under this part, subject to the following requirements:

''(A) NEEDS-BASED CRITERIA FOR ELIGIBILITY FOR, AND RECEIPT OF, LONG-TERM CARE SERVICES AND SUPPORTS.—The State establishes needs-based criteria for determining an individual's eligibility under the State plan for medical assistance for such long-term care services and supports, and if the individual is eligible for such services and supports, the specific services and supports that will be available under the State plan to the individual.

''(B) CRITERIA FOR INSTITUTIONALIZED VERSUS NON-INSTITUTIONALIZED SERVICES.—In establishing needs-based criteria, the State may establish criteria for determining eligibility for, and receipt of, services and supports provided in a facility or institution that are more stringent that the criteria established for eligibility and receipt of services and supports in a non-facility or non-institutionalized setting.

''(C) AUTHORITY TO LIMIT NUMBER OF ELIGIBLE INDIVIDUALS.—A State may limit the number of individuals who are eligible for such services and supports and may establish waiting lists for the receipt of such services and supports.

''(D) CRITERIA BASED ON INDIVIDUAL ASSESSMENT.—

''(i) IN GENERAL.—The criteria established by the State shall require an assessment of an individual's support needs and capabilities, and may take into account the inability of the individual to perform 2 or more activities of daily living (as defined in section 7702B(c)(2)(B) of the Internal Revenue Code of 1986) or the need for significant assistance to perform such activities, and such other risk factors as the State determines to be appropriate.

''(ii) ADJUSTMENT AUTHORITY.—The State plan amendment provides the State with the option to modify the criteria established under subparagraph (A) (without having to obtain prior approval from the Secretary) in the event that the enrollment of individuals eligible for services exceeds the projected enrollment, but only if—

''(I) the State provides at least 60 days notice to the Secretary and the public of the proposed modification;

''(II) the State deems an individual receiving long-term care services and supports on the basis of the most recent version of the criteria in effect prior to the effective date of the modification to be eligible for such services and supports for a period of at least 12 months beginning on the date the individual first received medical assistance for such services and supports; and

''(III) after the effective date of such modification, the State, at a minimum, applies the criteria for determining whether an individual requires the level of care provided in a facility or institutionalized setting which applied under the State plan immediately prior to the application of the modified criteria.

''(E) INDEPENDENT EVALUATION AND ASSESSMENT.—

''(i) ELIGIBILITY DETERMINATION.—The State uses an independent evaluation for making the determinations described in subparagraph (A).

''(ii) ASSESSMENT.—In the case of an individual who is determined to be eligible for long-term care services and supports, the State uses an independent assessment, based on the needs of the individual to—

''(I) determine a necessary level of services and supports to be provided, consistent with an individual's physical and mental capacity;

''(II) prevent the provision of unnecessary or inappropriate care; and

''(III) establish an individualized care plan for the individual in accordance with subparagraph (G).

''(F) ASSESSMENT.—The independent assessment required under subparagraph (E)(ii) shall include the following:

''(i) An objective evaluation of an individual's inability to perform 2 or more activities of daily living (as defined in section 7702B(c)(2)(B) of the Internal Revenue Code of 1986) or the need for significant assistance to perform such activities.

''(ii) A face-to-face evaluation of the individual by an individual trained in the assessment and evaluation of individuals whose physical or mental conditions trigger a potential need for long-term care services and supports.

''(iii) Where appropriate, consultation with the individual's family, spouse, guardian, or other responsible individual.

''(iv) Consultation with appropriate treating and consulting health and support professionals caring for the individual.

''(v) An examination of the individual's relevant history, medical records, and care and support needs, guided by best practices and research on effective strategies that result in improved health and quality of life outcomes.

''(vi) An evaluation of the ability of the individual or the individual's representative to

self-direct the purchase of, or control the receipt of, such services and supports if the individual so elects.

''(G) INDIVIDUALIZED CARE PLAN.—

''(i) IN GENERAL.—In the case of an individual who is determined to be eligible for long-term care services and supports, the State uses the independent assessment required under subparagraph (E)(ii) to establish a written individualized care plan for the individual.

''(ii) PLAN REQUIREMENTS.—The State ensures that the individualized care plan for an individual—

''(I) is developed—

''(aa) in consultation with the individual, the individual's treating physician, health care or support professional, or other appropriate individuals, as defined by the State, and, where appropriate the individual's family, caregiver, or representative; and

''(bb) taking into account the extent of, and need for, any family or other supports for the individual;

''(II) identifies the long-term care services and supports to be furnished to the individual (or, if the individual elects to self-direct the purchase of, or control the receipt of, such services and supports, funded for the individual); and

''(III) is reviewed at least annually and as needed when there is a significant change in the individual's circumstances.

''(iii) STATE REQUIREMENT TO OFFER ELECTION FOR SELF-DIRECTED SERVICES AND SUPPORTS.—

''(I) INDIVIDUAL CHOICE.—The State shall allow an individual or the individual's representative the opportunity to elect to receive self-directed long-term care services and supports in a manner which gives them the most control over such services and supports consistent with the individual's abilities and the requirements of subclauses (II) and (III).

''(II) SELF-DIRECTED.—The term 'self-directed' means, with respect to the long-term care services and supports offered under the State plan amendment, such services and supports for the individual which are planned and purchased under the direction and control of such individual or the individual's authorized representative, including the amount, duration, scope, provider, and location of such services and supports, under the State plan consistent with the following requirements:

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

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

''(III) PLAN REQUIREMENTS.—For purposes of subclause (II)(bb), the requirements of this subclause are that the plan—

''(aa) specifies those services and supports which the individual or the individual's authorized representative would be responsible for directing;

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

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

''(dd) is developed through a person-centered process that is directed by the individual or the individual's authorized representative, builds upon the individual's capacity to engage in activities that promote community life and that respects the individual's preferences, choices, and abilities, and involves families, friends, and professionals as desired or required by the individual or the individual's authorized representative;

''(ee) includes appropriate risk management techniques that recognize the roles and sharing of responsibilities in obtaining services and supports in a self-directed manner and assure the appropriateness of such plan based upon the resources and capabilities of the individual or the individual's authorized representative; and

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

''(IV) BUDGET PROCESS.—With respect to individualized budgets described in subclause (III)(ff), the State plan amendment—

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

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

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

''(H) QUALITY ASSURANCE; CONFLICT OF INTEREST STANDARDS.—

''(i) QUALITY ASSURANCE.—The State ensures that the provision of long-term care services and supports meets Federal and State guidelines for quality assurance.

''(ii) CONFLICT OF INTEREST STANDARDS.—The State establishes standards for the conduct of the independent evaluation and the independent assessment to safeguard against conflicts of interest.

''(I) REDETERMINATIONS AND APPEALS.—The State allows for at least annual redeterminations of eligibility, and appeals in accordance with the frequency of, and manner in which, redeterminations and appeals of eligibility are made under the State plan.

''(J) PRESUMPTIVE ELIGIBILITY FOR ASSESSMENT.—The State, at its option, elects to provide for a period of presumptive eligibility (not to exceed a period of 60 days) only for those individuals that the State has reason to believe may be eligible for long-term care services and supports. Such presumptive eligibility shall be limited to medical assistance for carrying out the independent evaluation and assessment under subparagraph (E) to determine an individual's eligibility for such services and if the individual is so eligible, the specific long-term care services and supports that the individual will receive.

''(2) DEFINITION OF INDIVIDUAL'S REPRESENTATIVE.—In this section, the term 'individual's representative' means, with respect to an individual, a parent, a family member, or a guardian of the individual, an advocate for the individual, or any other individual who is authorized to represent the individual.

''(b) SELF-DIRECTED PERSONAL ASSISTANCE SERVICES.—If a State includes personal care or personal assistance services in the long-term care services and supports available under the State plan, the State shall comply with the requirements of old section 1915(j) in the case of an individual who elects to self-direct the receipt of such care or services.

''SEC. 1918. TREATMENT OF INCOME AND RESOURCES FOR CERTAIN INSTITUTIONALIZED SPOUSES.

''Old section 1924 (relating to treatment of income and resources for certain institutionalized spouses), other than paragraphs (2) and (4)(A) of subsection (a) of such section, shall apply under this part.

''SEC. 1919. ANNUAL REPORTS.

''(a) IN GENERAL.—Each State that receives payments under this part shall submit an annual report to the Secretary, in such form and manner as the Secretary shall specify.

''(b) REQUIREMENTS.—The report shall include the following with respect to the most recent fiscal year ended:

''(1) The number of individuals served under the plan.

''(2) The number of individuals served by tier (preventive, emergency, low, medium, and high needs).

''(3) The number of individuals known to the State on waiting list for services (if any) and type of disability (physical, developmental, mental health) or aged.

''(4) Expenditures by service category.

''PART C—GRANTS TO STATES FOR SURVEY AND CERTIFICATION OF MEDICAL FACILITIES AND OTHER REQUIREMENTS

''SEC. 1931. AUTHORIZATION OF APPROPRIATIONS.

''For the purpose of carrying our Federal activities and providing grants to States for expenses necessary to carry out this part, there is authorized to be appropriated—

''(1) for fiscal year 2011, $300,000,000; and

''(2) for each succeeding fiscal year, the amount authorized under this section for the preceding fiscal year, increased by 5 percent.

''SEC. 1932. APPLICATION OF CERTAIN REQUIREMENTS UNDER PRE-MODERNIZED MEDICAID.

''The following old provisions shall apply under this part:

''(1) Old section 1902(a)(9) (relating to health standards and applicable requirements for laboratory services).

''(2) Old section 1902(a)(28) (relating to nursing facilities and nursing facility services).

''(3) Old sections 1902(a)(29) and 1908 (relating to a State program for the licensing of administrators of nursing homes).

''(4) Old section 1902(a)(33)(B) (relating to licensing health institutions).

''(5) Old section 1902(d) (relating to medical or utilization review functions).

''(6) Old section 1902(i) (relating to intermediate care facilities for the mentally retarded).

''(7) Old section 1902(y) (relating to psychiatric hospitals).

''(8) Paragraphs (2) and (6) of old section 1903(g) (relating to the Secretarial requirement to conduct sample onsite surveys of private and public institutions and recertifications for the need for certain services).

''(9) Old section 1903(q)(4)(B) (relating to the definition of a board and care facility).

''(10) Old section 1910 (relating to certification and approval of rural health clinics and intermediate care facilities for the mentally retarded).

''(11) Old section 1911 (relating to Indian Health Service facilities).

''(12) Old section 1913 (relating to hospital providers of nursing facility services).

''(13) Old section 1919 (relating to requirements for nursing facilities).

''PART D—GRANTS TO STATES FOR PROGRAM INTEGRITY

''SEC. 1941. AUTHORIZATION OF APPROPRIATIONS.

''(a) IN GENERAL.—For the purpose of carrying out Federal activities under this part and providing grants to States for expenses necessary to carry out this part, there is authorized to be appropriated—

''(1) for fiscal year 2011, $100,000,000; and

''(2) for each succeeding fiscal year, the amount authorized under this section for the preceding fiscal year, increased by 5 percent.

''(b) AVAILABILITY; AUTHORITY FOR USE OF FUNDS.—

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

''(2) AUTHORITY FOR USE OF FUNDS FOR TRANSPORTATION AND TRAVEL EXPENSES FOR ATTENDEES AT EDUCATION, TRAINING, OR CONSULTATIVE ACTIVITIES.—

''(A) IN GENERAL.—The Secretary may use amounts appropriated pursuant to subsection (a) to pay for transportation and the 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, of individuals described in subsection (b)(4) who attend education, training, or consultative activities conducted under the authority of that subsection.

''(B) PUBLIC DISCLOSURE.—The Secretary shall make available on a website of the Centers for Medicare & Medicaid Services that is accessible to the public—

''(i) the total amount of funds expended for each conference conducted under the authority of subsection (b)(4); and

''(ii) the amount of funds expended for each such conference that were for transportation and for travel expenses.

''(c) ANNUAL REPORT.—Not later than 180 days after the end of each fiscal year, the Secretary shall submit a report to Congress which identifies—

''(1) the use of funds appropriated pursuant to subsection (a); and

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

''SEC. 1942. APPLICATION OF CERTAIN REQUIREMENTS UNDER PRE-MODERNIZED MEDICAID.

''The following old provisions shall apply under this part:

''(1) Old subsections (a)(25) (other than subparagraph (E)) and (g) of section 1902 and section 1903(o) (relating to third party liability).

''(2) Old section 1902(a)(30)(B) (relating to hospital, intermediate care facility for the mentally retarded, or hospital for mental diseases admission screening and review requirements).

''(3) Old section 1902(a)(32) (relating to certain payment requirements).

''(4) Old section 1902(a)(35) (relating to disclosing entities under section 1124).

''(5) Old section 1902(a)(37) and the fifth sentence (relating to claims payment procedures).

''(6) Old section 1902(a)(44) (relating to payment for inpatient hospital services, services in an intermediate care facility for the mentally retarded, or inpatient mental hospital services).

''(7) Old sections 1902(a)(45) and 1912 (relating to assignment of rights of payment).

''(8) Old sections 1902(a)(49) and 1921 (relating to information and access to information concerning sanctions taken by State licensing authorities against health care practitioners and providers).

''(9) Old sections 1902(a)(61) and 1903(q) (relating to requirements for a medicaid fraud and abuse control unit).

''(10) Old section 1902(a)(64) (relating to reports from beneficiaries and others and data compilation requirements concerning alleged instances of waste, fraud, and abuse).

''(11) Old section 1902(a)(65) (relating to provider number and surety bond requirement for suppliers of durable medical equipment).

''(12) Old section 1902(a)(68) (relating to requirements for certain entities).

''(13) Old sections 1902(a)(69) and 1936 (relating to the Medicaid Integrity Program) other than paragraphs (1), (2)(A), and (3) of old section 1936(e).

''(14) Old section 1902(a)(70)(B)(iv) (relating to prohibitions on referrals and conflict of interest for certain brokers of non-emergency medical transportation).

''(15) Old sections 1902(a)(71) and 1940 (relating to a required asset verification program).

''(16) Old section 1902(p) (relating to exclusion of certain individuals or entities).

''(17) Old section 1902(x) (relating to unique identifiers for physicians).

''(18) Old section 1903(p) (relating to interstate collection of rights of support).

''(19) Old section 1903(r)(2) (relating to requirements for mechanized claims processing and information retrieval systems).

''(20) Old section 1903(u) (relating to erroneous excess payments), other than clause (v) of paragraph (1)(D).

''(21) Old section 1903(v) and the seventh sentence of old section 1902(a) (relating to limitations on payments for services furnished to aliens), other than subparagraphs (A) and (B) of paragraph (4).

''(22) Old section 1903(x) (relating to citizenship documentation).

''(23) Old section 1909 (relating to State false claims act requirements for increased State share of recoveries).

''(24) Old section 1914 (relating to withholding of Federal share of payments for certain Medicare providers).

''(25) Old section 1917 (relating to liens, adjustments and recoveries, and transfers of assets).

''(26) Old section 1922 (relating to correction and reduction plans for intermediate care facilities for the mentally retarded).

''PART E—GRANTS TO STATES FOR ADMINISTRATION

''SEC. 1951. AUTHORIZATION OF APPROPRIATIONS; PAYMENTS TO STATES.

''(a) IN GENERAL.—For the purpose of providing grants to States for administrative expenses necessary to carry out parts A and B, there is authorized to be appropriated—

''(1) for fiscal year 2011, $7,000,000,000; and

''(2) for each succeeding fiscal year, the amount authorized under this subsection for the preceding fiscal year, increased by 3 percent.

''(b) PAYMENTS TO STATES.—

''(1) IN GENERAL.—From the amount appropriated pursuant to subsection (a) for a fiscal year, the Secretary shall pay each State with approved plans under parts A and B for the fiscal year an amount equal to the product of the amount appropriated for the fiscal year and the ratio of the total amount of payments made to the State under paragraphs (2) through (7) of section 1903(a) for fiscal year 2008 (as such section was in effect for that fiscal year) to the total amount of such payments made to all States for such fiscal year.

''(2) PRO RATA ADJUSTMENT.—The Secretary shall make pro rata adjustments to the amounts determined under paragraph (1) for a fiscal year as necessary so as to not exceed the amount appropriated pursuant to subsection (a) for the fiscal year.

''SEC. 1952. COST-SHARING PROTECTIONS.

''(a) IN GENERAL.—A State may impose cost-sharing for individuals provided acute care medical assistance under a State plan under part A or long-term care services and supports under a State plan under part B consistent with the following:

''(1) The State may (in a uniform manner) require payment of monthly premiums or other cost-sharing set on a sliding scale based on family income.

''(2) A premium or other cost-sharing requirement imposed under paragraph (1) may only apply to the extent that, in the case of an individual whose family income—

''(A) exceeds 150 percent of the poverty line, the aggregate annual amount of such premium and other cost-sharing charges imposed under the plan does not exceed 5 percent of the individual's annual income; and

''(B) exceeds 250 percent of the poverty line, the aggregate annual amount of such premium and other cost-sharing charges do not exceed 7.5 percent of the individual's annual income.

''(3) A State shall not require prepayment of any premium or cost-sharing imposed pursuant to paragraph (1) and shall not terminate eligibility of an individual under the State plan on the basis of failure to pay any such premium or cost-sharing until such failure continues for a period of at least 60 days from the date on which the premium or cost-sharing became past due. The State may waive payment of any such premium or cost-sharing in any case where the State determines that requiring such payment would create an undue hardship.

''(b) APPLICATION TO INSTITUTIONALIZED INDIVIDUALS.—A State may impose cost-sharing consistent with subsection (a) to individuals who are patients in, or residents of, a medical institution or nursing facility except that rules relating to the post-eligibility treatment of income (including a minium monthly personal needs allowance) applicable to institutionalized individuals under old title XIX shall apply in the same manner to individuals eligible for long-term care services and supports under a State plan under part B.

''(c) POVERTY LINE DEFINED.—In this section, the term 'poverty line' has the meaning given such term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.

''SEC. 1953. APPLICATION OF CERTAIN REQUIREMENTS UNDER PRE-MODERNIZED MEDICAID.

''The following old provisions shall apply to the State plans under this title:

''(1) OLD STATE PLAN REQUIREMENTS.—

''(A) Old section 1902(a)(1) (relating to the requirement for plans to be in effect in all political subdivisions of the State).

''(B) Old section 1902(a)(2) (relating to State financial participation).

''(C) Old section 1902(a)(3) (relating to opportunity for a fair hearing).

''(D) Old section 1902(a)(4) (relating to administration).

''(E) Old section 1902(a)(5) (relating to designation of a single State agency).

''(F) Old section 1902(a)(6) (relating to reporting requirements).

''(G) Old section 1902(a)(7) (relating to restrictions on the use or disclosure of information).

''(H) Old section 1902(a)(8) (relating to applications for assistance).

''(I) Old section 1902(a)(11) (relating to cooperative agreements with other State agencies).

''(J) Old section 1902(a)(12) (relating to determinations of blindness).

''(K) Old section 1902(a)(13) (relating to determination of rates of payment for certain services), other than clause (iv) of subparagraph (A).

''(L) Subsections (a)(15) and (bb) of old section 1902(a) (relating to payment for services provided by rural health clinics and federally qualified health centers).

''(M) Old section 1902(a)(16) (relating to furnishing services to individuals when absent from the State).

''(N) Old section 1902(a)(22) (relating to certain administrative provisions).

''(O) Paragraphs (23) and (25)(D) of old section 1902(a) (relating to any willing provider requirements).

''(P) Old section 1902(a)(24) (relating to consultative services by other agencies).

''(Q) Old section 1902(a)(26) (relating to review of need for inpatient mental hospital services and written plan of care requirements).

''(R) Old section 1902(a)(27) (relating to provider record keeping requirements).

''(S) Old section 1902(a)(30)(A) (relating to utilization review).

''(T) Old section 1902(a)(31) (relating to written plan of care for services and review for intermediate care facility for the mentally retarded services).

''(U) Old section 1902(a)(33)(A) (relating to quality review requirements).

''(V) Old section 1902(a)(36) (relating to public availability of facility surveys).

''(W) Old section 1902(a)(38) (relating to the provision of information described in section 1128(b)(9) by certain entities).

''(X) Old section 1902(a)(39) (relating to the exclusion of certain entities).

''(Y) Old section 1902(a)(40) (relating to requirement for uniform reporting systems).

''(Z) Old section 1902(a)(41) (relating to notice to State medical licensing boards).

''(AA) Old section 1902(a)(42) (relating to certain audit requirements).

''(BB) Old section 1902(a)(48) (relating to eligibility cards).

''(CC) Old section 1902(a)(55) (relating to the receipt and initial processing of applications, but only to the extent such section is consistent with the policy embodied in the State plans under parts A and B).

''(DD) Subsections (a)(56) and (s) of old section 1902 (relating to adjusted payments for certain inpatient hospital services).

''(EE) Old section 1902(a)(59) (relating to maintenance of list of participating physicians).

''(FF) The second sentence of old section 1902 (relating to designation of certain State agencies).

''(GG) Old section 1902(b) (relating to limitations on approval of plans).

''(HH) Old section 1902(j) (relating to application of requirements to American Samoa and the Northern Mariana Islands).

''(2) OTHER OLD TITLE XIX REQUIREMENTS.—

''(A) Old section 1903(b)(4) (relating to limitations on payments to enrollment brokers).

''(B) Old section 1903(c) (relating to furnishing of services included in a program or plan under part B or C of the Individuals with Disabilities Education Act).

''(C) Old section 1903(d) (relating to payments).

''(D) Old section 1903(e) (relating to costs with respect to certain hospital services).

''(E) Old section 1903(i) (relating to limitations on payments).

''(F) Old section 1903(r) (relating to requirements for mechanized claims processing and information retrieval systems).

''(G) Subsections (b)(5) and (w) of old section 1903 (relating to limitations on payments related to provider taxes).

''(H) Old section 1904 (relating to operation of State plans).

''(I) Old sections 1902(a)(60) and 1908A (relating to medical child support).

''(J) Paragraphs (32)(D) and (62) of old section 1902(a) and section 1928 (relating to program for distribution of pediatric vaccines).

''PART F—OTHER PROVISIONS

''SEC. 1961. APPLICATION OF CERTAIN REQUIREMENTS UNDER PRE-MODERNIZED MEDICAID.

''The following old provisions shall apply under this part:

''(1) The third sentence of old section 1902 (relating to nonapplication of certain old provisions to a religious nonmedical health care institution).

''(2) Old section 1918 (relating to application of provisions of title II relating to subpoenas).

''(3) Old section 1939 (relating to references to laws directly affecting the Medicaid program.''.

(b) REPEAL OF TITLE XXI.—Effective January 1, 2011, title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.) is repealed.

SEC. 402. OUTREACH.

(a) AUTHORIZATION OF APPROPRIATIONS.—The following amounts are authorized to be appropriated to the Secretary of Health and Human Services:

(1) For fiscal year 2009, $100,000,000 for the design and implementation of a public outreach campaign to inform the public about the changes to the programs under such titles that take effect on January 1, 2011, as a result of the amendment made by section 401.

(2) For each of fiscal years 2010 and 2011, $200,000,000 to carry out such public outreach campaign.

(3) For fiscal year 2012, $50,000,000 to carry out such public outreach campaign.

(b) AVAILABILITY.—Funds appropriated under subsection (a) shall remain available for expenditure through September 30, 2012.

(c) AUTHORITY FOR USE OF FUNDS.—The Secretary may use funds made available under paragraphs (2) and (3) of subsection (a) to award grants to, or enter into contracts with, public or private entities, including States, local governments, schools, churches, and community groups.

SEC. 403. TRANSITION RULES; MISCELLANEOUS PROVISIONS.

(a) IN GENERAL.—

(1) Not later than June 30, 2010, a State that is one of the 50 States or the District of Columbia shall inform all individuals enrolled in a State plan under title XIX or XXI of the Social Security Act on such date (and any new enrollees after such date) of the changes to the programs under such titles that take effect on January 1, 2011, as a result of the amendment made by section 401.

(2) No State that is one of the 50 States or the District of Columbia shall approve any applications for medical assistance or child health assistance under a State plan under title XIX or XXI (as in effect for fiscal year 2010) after December 31, 2010.

(b) SUBMISSION OF LEGISLATIVE PROPOSAL FOR TECHNICAL AND CONFORMING AMENDMENTS.—Not later than 6 months after the date of enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a legislative proposal for such technical and conforming amendments as are necessary to carry out the amendments made by this Act.

Subtitle B—Supplemental Health Care Assistance for Low-Income Families

SEC. 411. SUPPLEMENTAL HEALTH CARE ASSISTANCE FOR LOW-INCOME FAMILIES.

Part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.) is amended by adding at the end the following:

''Subpart XI—Health Care Assistance to Low-Income Families

''SEC. 340A–1. FINANCIAL ASSISTANCE TO LOW-INCOME FAMILIES.

''(a) IN GENERAL.—The Secretary shall supplement the costs of private health insurance for eligible low-income families through the distribution of supplemental debit cards to eligible families, which may be used to pay for costs associated with health care for the members of such eligible families and provide direct support to such families in accessing health care.

''(b) ELIGIBILITY.—

''(1) ELIGIBLE FAMILIES.—To be eligible for financial assistance under this section—

''(A) a family shall—

''(i) consist of 2 or more individuals living together who are related by marriage, birth, adoption, or guardianship;

''(ii) have a gross income that does not exceed 200 percent of the poverty line, as applicable to a family of the size involved; and

''(iii) include at least 1 individual who is a dependent under the age of 19; and

''(B) no member of the family shall be covered by private health insurance.

''(2) DETERMINATION OF GROSS INCOME.—The gross income of a family shall be determined by taking the sum of the income of each family member who is at least age 21 but not older than age 65, except that the income of any member of the family who qualifies for coverage under Medicaid Part A or B shall not be counted.

''(3) LIMITATION ON INDIVIDUAL ELIGIBILITY; ASSISTANCE.—

''(A) IN GENERAL.—No individual who is a member of an eligible family under paragraph (1) is eligible to qualify separately for financial assistance under this section.

''(B) ALIENS.—The Secretary shall ensure that financial assistance under this section is not provided for costs associated with health care for any member of an eligible family who is an alien individual who is not a lawful permanent resident of the United States.

''(c) SUPPLEMENTAL DEBIT CARD FOR HEALTH CARE EXPENDITURES.—

''(1) IN GENERAL.—The Secretary shall issue to each eligible family that enrolls in the program in accordance with subsection (f) a supplemental debit card with a dollar-amount value, in accordance with subsection (d), that may be used to pay for qualifying health care expenses.

''(2) USE OF THE DEBIT CARD.—

''(A) QUALIFYING HEALTH CARE EXPENSES.—A supplemental debit card issued under this section may be used by members of the eligible family to pay for—

''(i) the purchase of health care insurance for any member of the family;

''(ii) cost sharing expenses related to health care, including deductibles, copayments, and coinsurance, for any member of the family; and

''(iii) the direct purchase of health care services and supplies for any member of the family.

''(B) GEOGRAPHIC RANGE.—Each supplemental debit card may be used to pay for qualifying health care expenses incurred anywhere in the 50 States or the District of Columbia.

''(C) LIMITATIONS.—No supplemental debit card shall be used to make a payment for any cost—

''(i) incurred prior to the determination of the family's eligibility for assistance under this section; or

''(ii) that is not a health-related expense.

''(3) ROLLOVER OF UNUSED AMOUNTS.—Not more than one-quarter of the annual dollar amount of a supplemental debit card that is unexpended at the end of each 12-month period may rollover—

''(A) to the family's supplemental debit card for expenditure during the subsequent 12-month period, provided that the family to which the supplemental debit card was issued in the previous 12-month period is eligible to receive a supplemental debit card in the subsequent 12-month period; or

''(B) to the family's health savings account (as defined in section 223(g)(2) of the Internal Revenue Code of 1986).

''(4) MONTHLY STATEMENTS.—The Secretary shall issue a monthly statement to each family to which a supplemental debit card has been issued under this section, which shall state each payment made with the family's supplemental debit card during the month covered by the statement, the dollar amount of each such payment, and the provider to which each such payment was made.

''(d) AMOUNT OF FINANCIAL ASSISTANCE.—

''(1) AMOUNTS FOR CALENDAR YEAR 2011.—Subject to paragraph (5), the amount of financial assistance available to each eligible

family during the calendar year 2011 shall be determined as follows:

''(A) Each family whose annual income does not exceed 100 percent of the poverty level, as applicable to a family of the size involved, shall receive $5,000.

''(B) Each family whose annual income exceeds 100 percent, but does not exceed 200 percent, of the poverty level, as applicable to a family of the size involved, shall receive an amount as follows:

''(i) For families whose annual income exceeds 100 percent but does not exceed 120 percent, of the poverty level, $4,000.

''(ii) For families whose annual income exceeds 120 percent but does not exceed 140 percent, of the poverty level, $3,500.

''(iii) For families whose annual income exceeds 140 percent but does not exceed 160 percent, of the poverty level, $3,000.

''(iv) For families whose annual income exceeds 160 percent but does not exceed 180 percent, of the poverty level, $2,500.

''(v) For families whose annual income exceeds 180 percent but does not exceed 200 percent, of the poverty level, $2,000.

''(2) ADDITIONAL AMOUNTS.—In addition to the amounts under paragraph (1), subject to paragraph (5), the following amounts shall be added to the supplemental debit cards of qualifying families:

''(A) For each pregnancy during which a pregnant woman's family is eligible for assistance under this section, an additional amount of $1,000 shall be added to the family's supplemental debit card, except that no family shall receive such additional $1,000 for any pregnancy for which the family received such amount in the previous 12-month period.

''(B) For each member of an eligible family who is less than 1 year old on any day within the calendar year in which the family is eligible for assistance, an additional amount of $500 shall be added to the family's supplemental debit card.

''(3) COST OF LIVING ADJUSTMENTS.—In the case of any taxable year beginning in a calendar year after 2011, each dollar amount contained in paragraphs (1) and (2) shall be increased in the same manner as the dollar amounts specified in section 25E(b)(3) of the Internal Revenue Code of 1986 are increased by the blended cost-of-living adjustment determined under subsection (k)(2) of section 25E of the Internal Revenue Code for the taxable year involved.

''(4) STATE OPTION TO INCREASE AMOUNTS.—At the option of each State, amounts in excess of the annual dollar amounts under paragraphs (1) and (2) may be provided through the supplemental debit card to eligible families in that State, but no Federal funds shall be paid to any State for any amount provided in excess of such annual dollar amount.

''(5) RISK ADJUSTMENT.—The Secretary may adjust the amount of financial assistance available to an eligible family for a calendar year under this section based on age, health indicators, and other factors that represent distinct patterns of health care services utilization and costs.

''(e) CONTRIBUTIONS OF STATES.—

''(1) IN GENERAL.—As a condition for receiving Federal funds under Part A or Part B of Medicaid, each State shall contribute 50 percent of the total amount expended under the supplemental debit card program by the participating families that reside within the State during the time that the family resides in that State. For purposes of this section, the residency of a family is determined by the residency the legally responsible head of the household.

''(2) PAYMENTS FROM STATES.—

''(A) BILLING NOTIFICATION.—

''(i) TIMING.—On June 30th and December 31st of each year, the Secretary shall send written notification to each State of that State's 50 percent share of expenses, as described in paragraph (1), for the 6-month period ending on the last day of the month previous to such notification.

''(ii) CONTENTS.—Each such notification to a State shall clearly state—

''(I) the payment amount due from the State;

''(II) the name of each individual for whom payment was made through the supplemental debit card program;

''(III) the health care provider to whom each payment was made;

''(IV) the amount of each payment; and

''(V) any other information, as the Secretary requires.

''(B) PAYMENTS.—Each State shall make a payment to the Secretary, in the amount billed, not later than 30 days after the billing notification date, in accordance with subparagraph (A)(i).

''(C) PENALTIES.—If a State fails to pay to the Secretary an amount required under subparagraph (B), interest shall accrue on such amount at the rate provided under old section 1903(d)(5) of the Social Security Act. The amount so owed and applicable interest shall be immediately offset against amounts otherwise payable to the State under this section, in accordance with the Federal Claims Collection Act of 1996 and applicable regulations.

''(f) ENROLLMENT.—

''(1) IN GENERAL.—The Secretary shall establish procedures and times for enrollment in the supplemental debit card program. Open enrollment shall be available not less than 4 times per calendar year.

''(2) TRANSITION OF INDIVIDUALS ENROLLED IN MEDICAID OR THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM.—

''(A) INFORMATION FROM THE STATES.—Each State shall—

''(i) not later than June 30, 2010, inform all individuals then enrolled in Medicaid or the State Children's Health Insurance Program (SCHIP), of the changes in effect beginning on January 1, 2011; and

''(ii) not later than October 31, 2010, redetermine the eligibility of each individual enrolled in Medicaid or SCHIP, other than those individuals who qualify for Medicaid or SCHIP as disabled, elderly, or a special population, for the supplemental debit card program, according to the eligibility criteria under subsection (b).

''(B) AUTOMATIC ENROLLMENT.—The Secretary shall provide for the automatic enrollment in the supplemental debit card program of all individuals who are enrolled in Medicaid or SCHIP and who have been redetermined by a State under subparagraph (A) to be eligible for Medicaid or SCHIP. Any individual who is determined by a State not to qualify for the supplemental debit card program may retain coverage under Medicaid or SCHIP until June 30, 2011.

''(3) ASSISTANCE WITH QUALIFIED HEALTH INSURANCE CREDIT.—Each State shall, to the extent practicable, provide individuals residing within the State with information regarding the qualified health insurance credit described in section 25E of the Internal Revenue Code of 1986, including information regarding eligibility for, and how to claim, such credit.

''(g) ADMINISTRATION.—

''(1) NATIONAL SYSTEM.—The Secretary may enter into contracts or agreements with a State, a consortium of States, or a private entity, including a bank, enrollment broker, or similar entity, to establish and maintain a unified national system to support the processes and transactions necessary to administer this section.

''(2) AUTOMATED SYSTEM.—The Secretary shall establish an automated means, such as an electronic benefit transfer system, by which the benefits under this section shall be transferred to eligible families.

''(3) VERIFICATION OF APPLICANT INFORMATION.—The Secretary may verify information provided by applicants with the appropriate Federal, State, and local agencies, including the Internal Revenue Service, the Social Security Administration, the Department of Labor, and child support enforcement agencies.

''(4) CHOICE COUNSELING.—The Secretary may enter into contracts or agreements with a State, a consortium of a State, or a private entity, including an enrollment broker or community organization or other organization, to educate eligible families about their options and to assist in their enrollment in the supplemental debit card plan.

''(5) APPEALS.—The Secretary shall establish an independent appeals process, to be administered by an entity separate from the entity that makes initial eligibility determinations, which shall be available to individuals who are denied benefits under the supplemental debit card program.

''(6) RESOLUTION OF ERRORS.—The Secretary shall provide for a reconciliation process with the States to resolve any errors and adjudicate disputes due to incomplete or false information in a family's application or in the billing process described in subsection (e).

''(7) PENALTIES FOR FALSE INFORMATION.—Any person who provides false information to qualify for the supplemental debit card program shall pay a penalty in the amount of 110 percent of the amount of assistance paid on behalf of such person and all members of such person's family.

''(h) IMPLEMENTATION PLAN.—Not later than 6 months after the date of enactment of this section, the Secretary shall submit to Congress a plan for implementing this program during fiscal years 2009–2012.

''(i) AUTHORIZATION OF APPROPRIATIONS.—

''(1) ADMINISTRATION OF THE SUPPLEMENTAL DEBIT CARD PROGRAM.—To administer the program under this section, there are authorized to be appropriated—

''(A) for fiscal year 2009, $300,000,000, for the design of a unified, national system of conducting the supplemental debit card program;

''(B) for fiscal year 2010, $1,000,000,000 for start-up costs, including, contracting, hiring and training employees, and testing the program; and

''(C) for fiscal year 2011 and each subsequent fiscal year, $3,000,000,000.

''(2) AUTHORIZATION OF BENEFITS UNDER THE SUPPLEMENTAL DEBIT CARD PROGRAM.—To provide the supplemental debit card benefits described in this section, there are authorized to be appropriated—

''(A) for fiscal year 2011, $24,020,000,000;

''(B) for fiscal year 2012, $25,220,000,000;

''(C) for fiscal year 2013, $26,480,000,000;

''(D) for fiscal year 2014, $27,810,000,000; and

''(E) for fiscal year 2015, $29,200,000,000.''.

TITLE V—FIXING MEDICARE FOR AMERICAN SENIORS

Subtitle A—Increasing Programmatic Efficiency, Economy, and Accountability

SEC. 501. ELIMINATING INEFFICIENCIES AND INCREASING CHOICE IN MEDICARE ADVANTAGE.

Part C of title XVIII of the Social Security Act is amended by adding at the end the following new section:

''PROTECTING MEDICARE BENEFITS FOR SENIORS

''SEC. 1860C–2. (a) COMPETITIVE BIDDING.—

''(1) IN GENERAL.—In order to promote competition among Medicare Advantage plans and to increase the quality of care furnished

under such plans, the Secretary shall establish and implement a competitive bidding mechanism under this part.

''(2) MECHANISM TO BEGIN IN 2011.—The mechanism established under paragraph (1) shall apply to all MA organizations and plans beginning in 2011.

''(3) NO EFFECT ON PART D BENEFITS.—The mechanism established under paragraph (1) shall not affect the provisions of this part relating to benefits under part D, including the bidding mechanism used for benefits under such part.

''(b) RULES FOR COMPETITIVE BIDDING MECHANISM.—Notwithstanding any other provision of this part, the following rules shall apply under the competitive bidding mechanism established under subsection (a).

''(1) BENCHMARK.—Benchmark amounts for an area for a year shall be established solely through the competitive bids of MA plans. The benchmark amount for each area for a year shall be the average bid of the plans in that area for that year. In establishing the benchmark for an area for a year under the preceding sentence, the Secretary shall exclude the highest and lowest bid for that area and year. The benchmark amount for an area for a year may not exceed the benchmark amount for that area and year that would have applied if this section had not been enacted.

''(2) BIDS.—The MA plan bid shall reflect the per capita payments that the MA plan will accept for providing a benefit package that is actuarially equivalent to 106 percent of the value of the original Medicare fee-for-service program option. MA plan bid submissions shall include data on plan average provider network contract rates compared to the rates under the original Medicare fee-for-service program option for the top 5 most common claim submissions per provider type.

''(3) RISK ADJUSTMENT.—The benchmark under paragraph (1) and the MA plan bid shall be risk adjusted using the risk adjustment requirements under this part.

''(4) BENEFICIARY PREMIUMS.—The MA monthly basic beneficiary premium for a beneficiary who enrolls in an MA plan whose plan bid is at or below the benchmark shall be zero and the beneficiary shall receive the full difference (if any) between the bid and the benchmark in the form of additional benefits or as a rebate on their premiums under this title. The MA monthly basic beneficiary premium for a beneficiary who enrolls in an MA plan whose plan bid is above the benchmark shall be equal to the amount by which the bid exceeds the benchmark.

''(5) BENCHMARK AMOUNTS FOR RURAL COUNTIES.—The Secretary may adjust the benchmark amount established under paragraph (1) for any rural county (as identified by the Secretary after consultation with the Secretary of Commerce) to encourage plan participation in such county.

''(6) EXISTING REQUIREMENTS.—Requirements relating to licensure, quality, and beneficiary protections that would otherwise apply under this part shall apply under the competitive bidding mechanism established under subsection (a).

''(c) WAIVER.—In order to implement the competitive bidding mechanism under established subsection (a), the Secretary may waive or modify requirements under this part.''.

SEC. 502. MEDICARE ACCOUNTABLE CARE ORGANIZATION DEMONSTRATION PROGRAM.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—In order to promote innovative care coordination and delivery that is cost-effective, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall conduct a demonstration program under the Medicare program under which—

(A) groups of providers meeting certain criteria may work together to manage and coordinate care for Medicare fee-for-service beneficiaries through an Accountable Care Organization (in this section referred to as an ''ACO''); and

(B) providers in participating ACOs are eligible for bonuses based on performance.

(2) MEDICARE FEE-FOR-SERVICE BENEFICIARY DEFINED.—In this section, the term ''Medicare fee-for-service beneficiary'' means an individual who is enrolled in the original medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act and not enrolled in an MA plan under part C of such title.

(b) ELIGIBLE ACOS.—

(1) IN GENERAL.—Subject to paragraph (2), the following provider groups are eligible to participate as ACOs under the demonstration program under this section:

(A) Physicians in group practice arrangements.

(B) Networks of individual physician practices.

(C) Partnerships or joint venture arrangements between hospitals and physicians.

(D) Partnerships or joint ventures, which may include pharmacists providing medication therapy management.

(E) Hospitals employing physicians.

(F) Integrated delivery systems.

(G) Community-based coalitions of providers.

(2) REQUIREMENTS.—An ACO shall meet the following requirements:

(A) The ACO shall have a formal legal structure that would allow the organization to receive and distribute bonuses to participating providers.

(B) The ACO shall include the primary care providers of at least 5,000 Medicare fee-for-service beneficiaries.

(C) The ACO shall be willing to become accountable for the overall care of the Medicare fee-for-service beneficiaries.

(D) The ACO shall provide the Secretary with a list of primary care and specialist physicians participating in the ACO to support the beneficiary assignment, implementation of performance measures, and the determination of bonus payments under the demonstration program.

(E) The ACO shall have in place contracts with a core group of key specialist physicians, a leadership and management structure, and processes to promote evidence-based medicine and to coordinate care.

(c) ASSIGNMENT OF MEDICARE FEE-FOR-SERVICE BENEFICIARIES.—

(1) IN GENERAL.—Under the demonstration program under this section, each Medicare fee-for-service Medicare beneficiary shall be automatically assigned to a primary care provider. Such assignment shall be based on the physician from whom the beneficiary received the most primary care in the preceding year.

(2) BENEFICIARIES MAY CONTINUE TO SEE PROVIDERS OUTSIDE OF THE ACO.—Under the demonstration program under this section, a Medicare fee-for-service Medicare beneficiary may continue to see providers in and outside of the ACO to which they have been assigned.

(d) BONUS PAYMENTS.—

(1) IN GENERAL.—Under the demonstration program, Medicare payments shall continue to be made to providers under the original Medicare fee-for-service program in the same manner as they would otherwise be made except that a participating ACO is eligible for bonuses if—

(A) it meets certain quality performance measures; and

(B) spending for their Medicare fee-for-service beneficiaries meets the requirement under paragraph (3).

(2) QUALITY.—Under the demonstration program under this section, providers meet the requirement under paragraph (1)(A) if they generally follow consensus-based guidelines established by non-government professional medical societies. Patient satisfaction and risk-adjusted outcomes shall be determined through an independent entity with medical expertise.

(3) REQUIREMENT RELATING TO SPENDING.—

(A) IN GENERAL.—An ACO shall only be eligible to receive a bonus payment if the average Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries over a two-year period is at least 2 percent below the average benchmark for the corresponding two-year period. The benchmark for each ACO shall be set using the most recent three years of total per-beneficiary spending for Medicare fee-for-service beneficiaries assigned to the ACO. Such benchmark shall be updated by the projected rate of growth in national per capita spending for the original medicare fee-for-service program, as projected (using the most recent three years of data) by the Chief Actuary of the Centers for Medicare & Medicaid Services.

(4) AMOUNT OF BONUS PAYMENTS.—The amount of the bonus payment to a participating ACO shall be one-half of the percentage point difference between the two-year average of their patients' Medicare expenditures and 98 percent of the two-year average benchmark. The bonus amount, in dollars, shall be equal to the bonus share multiplied by the benchmark for the most recent year.

(5) LIMITATION.—Bonus payments may only be made to an ACO if the primary care provider to which the Medicare fee-for-service beneficiary has been assigned under subsection (c) elects to participate in such ACO.

(e) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq.; 1395 et seq.) as may be appropriate for the purpose of carrying out the demonstration program under this section.

(f) REPORT.—Upon completion of the demonstration program under this section, the Secretary shall submit to Congress a report on the program together with such recommendations as the Secretary determines appropriate.

SEC. 503. REDUCING GOVERNMENT HANDOUTS TO WEALTHIER SENIORS.

(a) ELIMINATION OF ANNUAL INDEXING OF INCOME THRESHOLDS FOR REDUCED PART B PREMIUM SUBSIDIES.—

(1) IN GENERAL.—Paragraph (5) of section 1839(i) of the Social Security Act (42 U.S.C. 1395r(i)) is repealed.

(2) EFFECTIVE DATE.—The repeal made by paragraph (1) shall apply to premiums for months beginning after December 2010.

(b) INCOME-RELATED REDUCTION IN PART D PREMIUM SUBSIDY.—

(1) INCOME-RELATED REDUCTION IN PART D PREMIUM SUBSIDY.—

(A) 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) REDUCTION IN PREMIUM SUBSIDY 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 premium subsidy applicable to the premium under this section for a month after December 2010 shall be reduced (and the monthly beneficiary premium 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 reduction in premium subsidy under this paragraph.

''(E) PROCEDURES TO ASSURE CORRECT INCOME-RELATED REDUCTION IN PREMIUM SUBSIDY.—

''(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 reduction in premium subsidy 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 reduction in premium subsidy 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 reduction in premium subsidy 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.''.

(B) COLLECTION OF MONTHLY ADJUSTMENT AMOUNT.—Section 1860D–13(c) of the Social Security Act (42 U.S.C. 1395w–113(c)) is amended—

(i) in paragraph (1), by striking ''(2) and (3)'' and inserting ''(2), (3), and (4)''; and

(ii) 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 reduction in premium subsidy 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.''.

(2) CONFORMING AMENDMENTS.—

(A) MEDICARE.—Part D of title XVIII of the Social Security Act (42 U.S.C. 1395w–101 et seq.) is amended—

(i) in section 1860D–13(a)(1)—

(I) by redesignating subparagraph (F) as subparagraph (G);

(II) in subparagraph (G), as redesignated by subparagraph (A), by striking ''(D) and (E)'' and inserting ''(D), (E), and (F)''; and

(III) 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).''; and

(ii) in section 1860D–15(a)(1)(B), by striking ''paragraph (1)(B)'' and inserting ''paragraphs (1)(B) and (1)(F)''.

(B) 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—

(i) in the heading, by striking ''PART B PREMIUM SUBSIDY ADJUSTMENT'' and inserting ''PARTS B AND D PREMIUM SUBSIDY ADJUSTMENTS'';

(ii) in subparagraph (A)—

(I) in the matter preceding clause (i), by inserting ''or 1860D–13(a)(7)'' after ''1839(i)''; and

(II) in clause (vii), by inserting after ''subsection (i) of such section'' the following: ''or under section 1860D–13(a)(7) of such Act'';

(iii) in subparagraph (B)—

(I) by inserting ''or such section 1860D–13(a)(7)'' before the period at the end;

(II) as amended by clause (i), by inserting ''or for the purpose of resolving tax payer appeals with respect to any such premium adjustment'' before the period at the end; and

(III) by adding at the end the following new sentence: ''Officers, employees, and contractors of the Social Security Administration may disclose such return information to officers, employees, and contractors of the Department of Health and Human Services, the Office of Personnel Management, the Railroad Retirement Board, the Department of Justice, and the courts of the United States to the extent necessary to carry out the purposes described in the preceding sentence.''; and

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

''(C) TIMING OF DISCLOSURE.—Return information shall be disclosed to officers, employees, and contractors of the Social Security Administration under subparagraph (A) not later than the date that is 90 days prior to the date on which the taxpayer first becomes entitled to benefits under part A of title XVIII of the Social Security Act or eligible to enroll for benefits under part B of such title.''.

SEC. 504. REWARDING PREVENTION.

Section 1839 of the Social Security Act (42 U.S.C. 1395r) is amended—

(1) in subsection (a)(2), by striking ''and (i)'' and inserting ''(i), and (j)''; and

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

''(j)(1) With respect to the monthly premium amount for months after December 2010, the Secretary may adjust (under procedures established by the Secretary) the amount of such premium for an individual based on whether or not the individual participates in certain healthy behaviors, such as weight management, exercise, nutrition counseling, refraining from tobacco use, designating a health home, and other behaviors determined appropriate by the Secretary.

''(2) In making the adjustments under paragraph (1) for a month, the Secretary shall ensure that the total amount of premiums to be paid under this part for the month is equal to the total amount of premiums that would have been paid under this part for the month if no such adjustments had been made, as estimated by the Secretary.''.

SEC. 505. PROMOTING HEALTHCARE PROVIDER TRANSPARENCY.

(a) TRANSPARENCY.—Title XVIII of the Social Security Act is amended by adding at the end the following new section:

''PRICE TRANSPARENCY REQUIREMENTS

''SEC. 1899. (a) PRE-TREATMENT DISCLOSURE.—A provider of services (as defined in section 1861(u)) and a supplier (as defined in section 1861(d)) shall provide to each individual (regardless of whether or not the individual is a beneficiary under this title) who is scheduled to receive a treatment (or to begin a course of treatment) that is not for an emergency medical condition the estimated price that the provider of services or supplier will charge for the treatment (or course of treatment). Such price shall be determined at the time of scheduling.

''(b) POST-TREATMENT DISCLOSURE.—A provider of services (as so defined) and a supplier (as so defined) shall include with any bill that includes the charges for a treatment with respect to an individual (regardless of whether or not the individual is a beneficiary under this title), an itemized list of component charges for such treatment, including charges for drugs and medical equipment involved, as determined at the time of billing. With respect to each item included on such list, the provider of services or supplier shall include the price charged for the item.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to providers of services and suppliers on and after January 1, 2011.

SEC. 506. AVAILABILITY OF MEDICARE AND MEDICAID CLAIMS AND PATIENT ENCOUNTER DATA.

(a) PUBLIC AVAILABILITY.—Not later than 1 year after the date of enactment of this Act (and annually thereafter), the Secretary of Health and Human Services (in this section referred to as the ''Secretary''), shall make available to the public (including through an Internet website) data on claims and patient encounters under titles XVIII and XIX of the Social Security Act during the preceding calendar year. Such data shall be appropriately disaggregated and patient deidentified, as determined necessary by the Secretary in order to comply with the Federal regulations (concerning the privacy of individually identifiable health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996.

(b) PROVISION OF DATA TO STATE EXCHANGES AND HEALTH INSURANCE ISSUERS UNDER THE STATE EXCHANGE.—The Secretary shall submit such data directly to a State Exchange under title II and health insurance issuers under such Exchange (in a form and manner determined appropriate by the Secretary).

(c) MATCHING OF DATA.—The Secretary shall ensure that the total amount of claims under such titles during the preceding year

for which data is made available under subsection (a) is equal to the reported outlays from the Federal government and the States under such titles during the preceding years.

Subtitle B—Reducing Fraud and Abuse

SEC. 511. REQUIRING THE SECRETARY OF HEALTH AND HUMAN SERVICES TO CHANGE THE MEDICARE BENEFICIARY IDENTIFIER USED TO IDENTIFY MEDICARE BENEFICIARIES UNDER THE MEDICARE PROGRAM.

(a) PROCEDURES.—

(1) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, in order to protect beneficiaries from identity theft, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish and implement procedures to change the Medicare beneficiary identifier used to identify individuals entitled to benefits under part A of title XVIII of the Social Security Act or enrolled under part B of such title so that such an individual's social security account number is not used. Such procedures shall provide that the new Medicare beneficiary identifier includes biometric identification protections.

(2) MAINTAINING EXISTING HICN STRUCTURE.—In order to minimize the impact of the change under paragraph (1) on systems that communicate with Medicare beneficiary eligibility systems, the procedures under paragraph (1) shall provide that the new Medicare beneficiary identifier maintain the existing Health Insurance Claim Number structure.

(3) PROTECTION AGAINST FRAUD.—The procedures under paragraph (1) shall provide for a process for changing the Medicare beneficiary identifier for an individual to a different identifier in the case of the discovery of fraud, including identity theft.

(4) PHASE-IN AUTHORITY.—

(A) IN GENERAL.—Subject to subparagraphs (B) and (C), the Secretary may phase in the change under paragraph (1) in such manner as the Secretary determines appropriate.

(B) LIMIT.—The phase-in period under subparagraph (A) shall not exceed 10 years.

(C) NEWLY ENTITLED AND ENROLLED INDIVIDUALS.—The Secretary shall ensure that the change under paragraph (1) is implemented not later than January 1, 2010, with respect to any individual who first becomes entitled to benefits under part A of title XVIII of the Social Security Act or enrolled under part B of such title on or after such date.

(b) EDUCATION AND OUTREACH.—The Secretary shall establish a program of education and outreach for individuals entitled to, or enrolled for, benefits under part A of title XVIII of the Social Security Act or enrolled under part B of such title, providers of services (as defined in subsection (u) of section 1861 of such Act (42 U.S.C. 1395x)), and suppliers (as defined in subsection (d) of such section) on the change under paragraph (1).

(c) DATA MATCHING.—

(1) ACCESS TO CERTAIN INFORMATION.—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—

''(i) enter into an agreement with the Secretary for the purpose of matching data in the system of records of the Commissioner with data in the system of records of the Secretary, so long as the requirements of subparagraphs (A) and (B) of paragraph (3) are met, in order to determine—

''(I) whether a beneficiary under the program under title XVIII, XIX, or XXI is dead, imprisoned, or otherwise not eligible for benefits under such program; and

''(II) whether a provider of services or a supplier under the program under title XVIII, XIX, or XXI is dead, imprisoned, or otherwise not eligible to furnish or receive payment for furnishing items and services under such program; and

''(ii) include in such agreement safeguards to assure the maintenance of the confidentiality of any information disclosed and procedures to permit the Secretary to use such information for the purpose described in clause (i).

''(B) Information provided pursuant to an agreement under this paragraph shall be provided at such time, in such place, and in such manner as the Commissioner determines appropriate.

''(C) Information provided pursuant to an agreement under this paragraph shall include information regarding whether—

''(i) the name (including the first name and any family name or surname), the date of birth (including the month, day, and year), and social security number of an individual provided to the Commissioner match the information contained in the Commissioner's records, and

''(ii) such individual is shown on the records of the Commissioner as being deceased.''.

(2) INVESTIGATION BASED ON CERTAIN INFORMATION.—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. ACCESS TO CERTAIN DATA AND INVESTIGATION OF CLAIMS INVOLVING INDIVIDUALS WHO ARE NOT ELIGIBLE FOR BENEFITS OR ARE NOT ELIGIBLE PROVIDERS OF SERVICES OR SUPPLIERS.

''(a) DATA AGREEMENT.—The Secretary shall enter into an agreement with the Commissioner of Social Security pursuant to section 205(r)(9).

''(b) INVESTIGATION OF CLAIMS INVOLVING CERTAIN INDIVIDUALS WHO ARE NOT ELIGIBLE FOR BENEFITS OR ARE NOT ELIGIBLE PROVIDERS OF SERVICES OR SUPPLIERS.—

''(1) IN GENERAL.—The Secretary shall, in the case where a provider of services or a supplier under the program under title XVIII, XIX, or XXI submits a claim for payment for items or services furnished to an individual who the Secretary determines, as a result of information provided pursuant to such agreement, is not eligible for benefits under such program, or where the Secretary determines, as a result of such information, that such provider of services or supplier is not eligible to furnish or receive payment for furnishing such items or services, conduct an investigation with respect to the provider of services or supplier. If the Secretary determines further action is appropriate, the Secretary shall refer the investigation to the Inspector General of the Department of Health and Human Services as soon as practicable.

''(2) ASSESSMENT OF IMPLEMENTATION AND EFFECTIVENESS BY THE OIG.—The Inspector General of the Department of Health and Human Services shall test the implementation of the provisions of this section (including the implementation of the agreement under section 205(r)(9)) and conduct such period assessments of such implementation as the Inspector General determines necessary to determine the effectiveness of such implementation.''.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

SEC. 512. USE OF TECHNOLOGY FOR REAL-TIME DATA REVIEW.

Title XVIII of the Social Security Act, as amended by this Act, is amended by adding at the end the following new section:

''USE OF TECHNOLOGY FOR REAL-TIME DATA REVIEW

''SEC. 1899A. (a) IN GENERAL.—The Secretary shall establish procedures for the use of technology (including front-end, pre-payment 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.

''(b) COMPETITIVE BIDDING.—The procedures established under subsection (a) shall ensure that the implementation of such technology is conducted through a competitive bidding process.''.

SEC. 513. DETECTION OF MEDICARE FRAUD AND ABUSE.

(a) IN GENERAL.—Section 1893 of the Social Security Act (42 U.S.C. 1395ddd) is amended—

(1) in subsection (b), by adding at the end the following new paragraph:

''(7) Implementation of fraud and abuse detection methods under subsection (i).'';

(2) in subsection (c), by adding at the end of the flush matter following paragraph (4), the following new sentence ''In the case of an activity described in subsection (b)(8), an entity shall only be eligible to enter into a contract under the Program to carry out the activity if the entity is selected through a competitive bidding process in accordance with subsection (i)(3).''; and

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

''(i) DETECTION OF MEDICARE FRAUD AND ABUSE.—

''(1) ESTABLISHMENT OF SYSTEM TO IDENTIFY COUNTIES MOST VULNERABLE TO FRAUD.—Not later than 6 months after the date of enactment of this subsection, the Secretary shall establish a system to identify the 50 counties most vulnerable to fraud with respect to items and services furnished by providers of services (other than hospitals and critical access hospitals) and suppliers based on the degree of county-specific reimbursement and analysis of payment trends under this title. The Secretary shall designate the counties identified under the preceding sentence as 'high risk areas'.

''(2) FRAUD AND ABUSE DETECTION.—

''(A) INITIAL IMPLEMENTATION.—The Secretary shall establish procedures for the implementation of fraud and abuse detection methods under this title with respect to items and services furnished by such providers of services and suppliers in high risk areas designated under paragraph (1) (and, beginning not later than 18 months after the date of enactment of this subsection, with respect to items and services furnished by such providers of services and suppliers in areas not so designated) including the following:

''(i) Data analysis to establish prepayment claim edits designed to target the claims for payment under this title for such items and services that are most likely to be fraudulent.

''(ii) Prepayment benefit integrity reviews for claims for payment under this title for such items and services that are suspended as a result of such edits.

''(B) REQUIREMENT FOR PARTICIPATION.—In no case may a provider of services or supplier who does not meet the requirements under subparagraph (A) participate in the program under this title.

''(C) EXPANDED IMPLEMENTATION.—Not later than 24 months after the date of enactment of this subsection, the Secretary shall establish procedures for the implementation of such fraud and abuse detection methods under this title with respect to items and services furnished by all providers of services

and suppliers, including those not in high risk areas designated under paragraph (1).

''(3) COMPETITIVE BIDDING.—In selecting entities to carry out this subsection, the Secretary shall use a competitive bidding process.

''(4) REPORT TO CONGRESS.—The Secretary shall submit to Congress an annual report on the effectiveness of activities conducted under this subsection, including a description of any savings to the program under this title as a result of such activities and the overall administrative cost of such activities and a determination as to the amount of funding needed to carry out this subsection for subsequent fiscal years, together with recommendations for such legislation and administrative action as the Secretary determines appropriate.''.

(b) AUTHORIZATION OF APPROPRIATIONS.—To carry out the amendments made by this section, there are authorized to be appropriated—

(1) such sums as may be necessary, not to exceed $50,000,000, for each of fiscal years 2010 through 2014; and

(2) such sums as may be necessary, not to exceed an amount the Secretary determines appropriate in the most recent report submitted to Congress under section 1893(j)(4) of the Social Security Act, as added by subsection (a), for each subsequent fiscal year.

SEC. 514. EDITS ON 855S MEDICARE ENROLLMENT APPLICATION AND EXEMPTION OF PHARMACISTS FROM SURETY BOND REQUIREMENT.

(a) EDITS ON 855S MEDICARE ENROLLMENT APPLICATION.—Section 1834(a) of the Social Security Act (42 U.S.C. 1395m(a)) is amended by adding at the end the following new paragraphs:

''(22) CONFIRMATION WITH NATIONAL SUPPLIER CLEARINGHOUSE PRIOR TO PAYMENT.—

''(A) IN GENERAL.—Not later than 1 year after the date of enactment of this paragraph, the Secretary shall establish procedures to require carriers, prior to paying a claim for payment for durable medical equipment, prosthetics, orthotics, and supplies under this title, to confirm with the National Supplier Clearinghouse—

''(i) that the National Provider Identifier of the physician or practitioner prescribing or ordering the item or service is valid and active;

''(ii) that the Medicare identification number of the supplier is valid and active; and

''(iii) that the item or service for which the claim for payment is submitted was properly identified on the CMS–855S Medicare enrollment application.

''(B) ONLINE DATABASE FOR IMPLEMENTATION.—Not later than 18 months after the date of enactment of this paragraph, the Secretary shall establish an online database similar to that used for the National Provider Identifier to enable providers of services, accreditors, carriers, and the National Supplier Clearinghouse to view information on specialties and the types of items and services each supplier has indicated on the CMS–855S Medicare enrollment application submitted by the supplier.

''(C) NOTIFICATION OF CLAIM DENIAL AND RESUBMISSION.—In the case where a claim for payment for durable medical equipment, prosthetics, orthotics, and supplies under this title is denied because the item or service furnished does not correctly match up with the information on file with the National Supplier Clearinghouse—

''(i) the National Supplier Clearinghouse shall—

''(I) provide the supplier written notification of the reason for such denial; and

''(II) allow the supplier 60 days to provide the National Supplier Clearinghouse with appropriate certification, licensing, or accreditation; and

''(ii) the Secretary shall waive applicable requirements relating to the time frame for the submission of claims for payment under this title in order to permit the resubmission of such claim if payment of such claim would otherwise be allowed under this title.

''(D) IMPROVEMENTS TO MEDICARE ENROLLMENT APPLICATION.—The Secretary shall establish procedures under which a prospective supplier of durable medical equipment, prosthetics, orthotics, and supplies under this title shall certify, as part of the CMS–855S Medicare enrollment application submitted by such supplier, under penalty of perjury, that the information provided by the supplier on such application is accurate to the best of the supplier's knowledge.

''(23) TERMINATION OF PARTICIPATION FOR SUBMISSION OF FRAUDULENT CLAIMS.—If the Secretary finds that a supplier of durable medical equipment, prosthetics, orthotics, and supplies under this title has submitted fraudulent claims for payment under this title, the Secretary shall terminate the suppliers participation under this title. Not later than 1 year after the date of enactment of this paragraph, the Secretary shall establish a process under which a supplier whose participation has been terminated under the preceding sentence may appeal such termination and such appeal shall be resolved not later than 60 days after the date on which the appeal was made.''.

(b) EXEMPTION OF PHARMACISTS FROM SURETY BOND REQUIREMENT.—Section 1834(a)(16) of the Social Security Act (42 U.S.C. 1395m(a)(16)) is amended, in the second sentence, by inserting ''and shall waive such requirement in the case of a pharmacist'' before the period at the end.

SEC. 515. GAO STUDY AND REPORT ON EFFECTIVENESS OF SURETY BOND REQUIREMENTS FOR SUPPLIERS OF DURABLE MEDICAL EQUIPMENT IN COMBATING FRAUD.

(a) STUDY.—The Comptroller General of the United States shall conduct a study on the effectiveness of the surety bond requirement under section 1834(a)(16) of the Social Security Act (42 U.S.C. 1395m(a)(16)) in combating fraud.

(b) REPORT.—Not later than 1 year 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.

TITLE VI—ENDING LAWSUIT ABUSE

SEC. 601. STATE GRANTS TO CREATE HEALTH COURT SOLUTIONS.

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:

''SEC. 399R. STATE GRANTS TO CREATE HEALTH COURT SOLUTIONS.

''(a) IN GENERAL.—The Secretary may award grants to States for the development, implementation, and evaluation of alternatives to current tort litigation that comply with this section, for the resolution of disputes concerning injuries allegedly caused by health care providers or health care organizations.

''(b) CONDITIONS FOR DEMONSTRATION GRANTS.—

''(1) APPLICATION.—To be eligible to receive a grant under this section, a State shall submit to the Secretary an application at such time, in such manner, and containing such information as may be required by the Secretary. A grant shall be awarded under this section on such terms and conditions as the Secretary determines appropriate.

''(2) STATE REQUIREMENTS.—To be eligible to receive a grant under this section, a State shall—

''(A) develop and implement an alternative to current tort litigation for resolving disputes over injuries allegedly caused by health care providers or health care organizations based on one or more of the models described in subsection (d); and

''(B) implement policies that provide for a reduction in health care errors through the collection and analysis by organizations that engage in voluntary efforts to improve patient safety and the quality of health care delivery, of patient safety data related to disputes resolved under the alternatives under subparagraph (A).

''(3) DEMONSTRATION OF EFFECTIVENESS.—To be eligible to receive a grant under subsection (a), a State shall demonstrate how the proposed alternative to be implemented under paragraph (2)(A) will—

''(A) make the medical liability system of the State more reliable through the prompt and fair resolution of disputes;

''(B) encourage the early disclosure of health care errors;

''(C) enhance patient safety; and

''(D) maintain access to medical liability insurance.

''(4) SOURCES OF COMPENSATION.—To be eligible to receive a grant under subsection (a), a State shall identify the sources from, and methods by which, compensation would be paid for medical liability claims resolved under the proposed alternative to current tort litigation implemented under paragraph (2)(A). Funding methods shall, to the extent practicable, provide financial incentives for activities that improve patient safety.

''(5) SCOPE.—

''(A) IN GENERAL.—To be eligible to receive a grant under subsection (a), a State shall utilize the proposed alternative identified under paragraph (2)(A) for the resolution of all types of disputes concerning injuries allegedly caused by health care providers or health care organizations.

''(B) CURRENT STATE EFFORTS TO ESTABLISH ALTERNATIVE TO TORT LITIGATION.—

''(i) IN GENERAL.—Nothing in this section shall be construed to limit the efforts that any State has made prior to the date of enactment of this section to establish any alternative to tort litigation.

''(ii) ALTERNATIVE FOR PRACTICE AREAS OR INJURIES.—In the case of a State that has established an alternative to tort litigation for a certain area of health care practice or a category of injuries, the alternative selected as provided for in this section shall supplement not replace or invalidate such established alternative unless the State intends otherwise.

''(6) NOTIFICATION OF PATIENTS.—To be eligible to receive a grant under subsection (a), the State shall demonstrate how patients will be notified when they are receiving health care services that fall within the scope of the alternative selected under this section by the State to current tort litigation.

''(c) REPRESENTATION BY COUNSEL.—A State that receives a grant under this section may not preclude any party to a dispute that falls within the jurisdiction of the alternative to current tort litigation that is implemented under the grant from obtaining legal representation at any point during the consideration of the claim under such alternative.

''(d) MODELS.—

''(1) IN GENERAL.—The models in this section are the following:

''(2) EXPERT PANEL REVIEW AND EARLY OFFER GUIDELINES.—

''(A) IN GENERAL.—A State may use amounts received under a grant under this

section to develop and implement an expert panel and early offer review system that meets the requirements of this paragraph.

''(B) ESTABLISHMENT OF PANEL.—Under the system under this paragraph, the State shall establish an expert panel to review any disputes concerning injuries allegedly caused by health care providers or health care organizations according to the guidelines described in this paragraph.

''(C) COMPOSITION.—

''(i) IN GENERAL.—An expert panel under this paragraph shall be composed of 3 medical experts (either physicians or health care professionals) and 3 attorneys to be appointed by the head of the State agency responsible for health.

''(ii) LICENSURE AND EXPERTISE.—Each physician or health care professional appointed to an expert panel under clause (i) shall—

''(I) be appropriately credentialed or licensed in the State in which the dispute takes place to deliver health care services; and

''(II) typically treat the condition, make the diagnosis, or provide the type of treatment that is under review.

''(iii) INDEPENDENCE.—

''(I) IN GENERAL.—Subject to subclause (II), each individual appointed to an expert panel under this paragraph shall—

''(aa) not have a material familial, financial, or professional relationship with a party involved in the dispute reviewed by the panel; and

''(bb) not otherwise have a conflict of interest with such a party.

''(II) EXCEPTION.—Nothing in subclause (I) shall be construed to prohibit an individual who has staff privileges at an institution where the treatment involved in the dispute was provided from serving as a member of an expert panel merely on the basis of such affiliation, if the affiliation is disclosed to the parties and neither party objects.

''(iv) PRACTICING HEALTH CARE PROFESSIONAL IN SAME FIELD.—

''(I) IN GENERAL.—In a dispute before an expert panel that involves treatment, or the provision of items or services—

''(aa) by a physician, the medical experts on the expert panel shall be practicing physicians (allopathic or osteopathic) of the same or similar specialty as a physician who typically treats the condition, makes the diagnosis, or provides the type of treatment under review; or

''(bb) by a health care professional other than a physician, at least two medical experts on the expert panel shall be practicing physicians (allopathic or osteopathic) of the same or similar specialty as the health care professional who typically treats the condition, makes the diagnosis, or provides the type of treatment under review, and, if determined appropriate by the State agency, the third medical expert shall be a practicing health care professional (other than such a physician) of such a same or similar specialty.

''(II) PRACTICING DEFINED.—In this paragraph, the term 'practicing' means, with respect to an individual who is a physician or other health care professional, that the individual provides health care services to individual patients on average at least 2 days a week.

''(v) PEDIATRIC EXPERTISE.—In the case of dispute relating to a child, at least 1 medical expert on the expert panel shall have expertise described in clause (iv)(I) in pediatrics.

''(D) DETERMINATION.—After a review, an expert panel shall make a determination as to the liability of the parties involved and compensation based on a schedule of compensation that is developed by the panel. Such a schedule shall at least include—

''(i) payment for the net economic loss incurred by the patient, on a periodic basis, reduced by any payments received by the patient under—

''(I) any health or accident insurance;

''(II) any wage or salary continuation plan; or

''(III) any disability income insurance;

''(ii) payment for the non-economic damages incurred by the patient, if appropriate for the injury, based on a defined payment schedule developed by the State, in consultation with relevant experts and with the Secretary;

''(iii) reasonable attorney's fees; and

''(iv) regular updates of the schedule under clause (ii) as necessary.

''(E) ACCEPTANCE.—If the parties to a dispute who come before an expert panel under this paragraph accept the determination of the expert panel concerning liability and compensation, such compensation shall be paid to the claimant and the claimant shall agree to forgo any further action against the health care providers or health care organizations involved.

''(F) FAILURE TO ACCEPT.—If any party decides not to accept the expert panel's determination under this paragraph, the State may choose whether to allow the panel to review the determination de novo, with deference, or to provide an opportunity for parties to reject the determination of the panel.

''(G) REVIEW BY STATE COURT AFTER EXHAUSTION OF ADMINISTRATIVE REMEDIES.—

''(i) RIGHT TO FILE.—If the State elects not to permit the expert panel under this paragraph to conduct its own reviews of determinations, or if the State elects to permit such reviews but a party is not satisfied with the final decision of the panel after such a review, the party shall have the right to file a claim relating to the injury involved in a State court of competent jurisdiction.

''(ii) FORFEIT OF AWARDS.—Any party filing an action in a State court under clause (i) shall forfeit any compensation award made under subparagraph (C).

''(iii) ADMISSIBILITY.—The determinations of the expert panel pursuant to a review under subparagraph (C) shall be admissible into evidence in any State court proceeding under this subparagraph.

''(3) ADMINISTRATIVE HEALTH CARE TRIBUNALS.—

''(A) IN GENERAL.—A State may use amounts received under a grant under this section to develop and implement an administrative health care tribunal system under which the parties involved shall have the right to request a hearing to review any dispute concerning injuries allegedly caused by health care providers or health care organizations before an administrative health care tribunal established by the State involved.

''(B) REQUIREMENTS.—In establishing an administrative health care tribunal under this paragraph, a State shall—

''(i) ensure that such tribunals are presided over by special judges with health care expertise who meet applicable State standards for judges and who agree to preside over such court voluntarily;

''(ii) provide authority to such judges to make binding rulings, rendered in written decisions, on standards of care, causation, compensation, and related issues with reliance on independent expert witnesses commissioned by the tribunal;

''(iii) establish a legal standard for the tribunal that shall be the same as the standard that would apply in the State court of competent jurisdiction which would otherwise handle the claim; and

''(iv) provide for an appeals process to allow for review of decisions by State courts.

''(C) DETERMINATION.—After a tribunal conducts a review under this paragraph, the tribunal shall make a determination as to the liability of the parties involved and the amount of compensation that should be paid based on a schedule of compensation developed by the tribunal. Such a schedule shall at a minimum include—

''(i) payment for the net economic loss incurred by the patient, on a periodic basis, reduced by any payments received by the patient under—

''(I) any health or accident insurance;

''(II) any wage or salary continuation plan; or

''(III) any disability income insurance;

''(ii) payment for the non-economic damages incurred by the patient, if appropriate for the injury, based on a defined payment schedule developed by the State in consultation with relevant experts and with the Secretary;

''(iii) reasonable attorney's fees; and

''(iv) regular updates of the schedule under clause (ii) as necessary.

''(D) REVIEW BY STATE COURT AFTER EXHAUSTION OF ADMINISTRATIVE REMEDIES.—

''(i) RIGHT TO FILE.—Nothing in this paragraph shall be construed to prohibit any individual who is not satisfied with the determinations of a tribunal under this paragraph, from filing a claim for the injury involved in a State court of competent jurisdiction.

''(ii) FORFEIT OF AWARD.—Any party filing an action in a State court under clause (i) shall forfeit any compensation award made under subparagraph (C).

''(iii) ADMISSIBILITY.—The determinations of the tribunal under subparagraph (C) shall be admissible into evidence in any State court proceeding under this subparagraph.

''(4) EXPERT PANEL REVIEW AND ADMINISTRATIVE HEALTH CARE TRIBUNAL COMBINATION MODEL.—

''(A) IN GENERAL.—A State may use amounts received under a grant under this section to develop and implement an expert panel review and administrative health care tribunal combination system to review any dispute concerning injuries allegedly caused by health care providers or health care organizations. Under such system, a dispute concerning injuries allegedly caused by health care providers or health care organizations shall proceed through the procedures described in this subparagraph prior to the submission of such dispute to a State court.

''(B) GENERAL PROCEDURE.—

''(i) ESTABLISHMENT OF EXPERT PANEL.—Prior to submitting any dispute described in subparagraph (A) to an administrative health care tribunal under the system established under this paragraph, the State shall establish an expert panel (in accordance with subparagraph (C)) to review the allegations involved in such dispute.

''(ii) REFERRAL TO TRIBUNAL.—If either party to a dispute described in clause (i) fails to accept the determination of the expert panel, the dispute shall then be referred to an administrative health care tribunal (in accordance with subparagraph (D).

''(C) EXPERT REVIEW PANEL.—

''(i) IN GENERAL.—The provisions of paragraph (2) shall apply with respect to the establishment and operation of an expert review panel under this subparagraph, except that the subparagraphs (F) and (G) of such paragraph shall not apply.

''(ii) FAILURE TO ACCEPT DETERMINATION OF PANEL.—If any party to a dispute before an expert panel under this subparagraph refuses to accept the panel's determination, the dispute shall be referred to an administrative health care tribunal under subparagraph (D).

''(D) ADMINISTRATIVE HEALTH CARE TRIBUNALS.—

''(i) IN GENERAL.—Upon the failure of any party to accept the determination of an expert panel under subparagraph (C), the parties shall request a hearing concerning the liability or compensation involved by an administrative health care tribunal established by the State involved under this subparagraph.

''(ii) REQUIREMENTS.—The provisions of paragraph (3) shall apply with respect to the establishment and operation of an administrative health care tribunal under this subparagraph.

''(iii) FORFEIT OF AWARDS.—Any party proceeding to the second step-administrative health care tribunal-under this model shall forfeit any compensation awarded by the expert panel.

''(iv) ADMISSIBILITY.—The determinations of the expert panel under subparagraph (C) shall be admissible into evidence in any administrative health care tribunal proceeding under this subparagraph.

''(E) RIGHT TO FILE.—Nothing in this paragraph shall be construed to prohibit any individual who is not satisfied with the determination of the tribunal (after having proceeded through both the expert panel under subparagraph (C) and the tribunal under subparagraph (D)) from filing a claim for the injury involved in a State court of competent jurisdiction.

''(F) ADMISSIBILITY.—The determinations of both the expert panel and the tribunal under this paragraph shall be admissible into evidence in any State court proceeding under this paragraph.

''(G) FORFEIT OF AWARDS.—Any party filing an action in State court under subparagraph (E) shall forfeit any compensation award made by both the expert panel and the administrative health care tribunal under this paragraph.

''(e) DEFINITIONS.—In this section:

''(1) CURRENT TORT LITIGATION.—The term 'current tort litigation' means the tort litigation system existing in the State on the date on which the State submits an application under subsection (b)(1), for the resolution of disputes concerning injuries allegedly caused by health care providers or health care organizations.

''(2) HEALTH CARE ORGANIZATION.—The term 'health care organization' means any individual or entity that is obligated to provide, pay for, or administer health benefits under any health plan.

''(3) NET ECONOMIC LOSS.—The term 'net economic loss' means—

''(A) reasonable expenses incurred for products, services and accommodations needed for health care, training and other remedial treatment and care of an injured individual;

''(B) reasonable and appropriate expenses for rehabilitation treatment and occupational training;

''(C) 100 percent of the loss of income from work that an injured individual would have performed if not injured, reduced by any income from substitute work actually performed; and

''(D) reasonable expenses incurred in obtaining ordinary and necessary services to replace services an injured individual would have performed for the benefit of the individual or the family of such individual if the individual had not been injured.

''(4) NON-ECONOMIC DAMAGES.—The term 'non-economic damages' means losses for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), injury to reputation, and all other non-pecuniary losses of any kind or nature, to the extent permitted under State law.

''(f) FUNDING.—

''(1) ONE-TIME INCREASE IN MEDICAID PAYMENT.—In the case of a State awarded a grant to carry out this section, the total amount of the Federal payment determined for the State under section 1913 of the Social Security Act (as amended by section 401) for fiscal year 2011 (in addition to the any increase applicable for that fiscal year under section 203(b) but determined without regard to any such increase) shall be increased by an amount equal to 1 percent of the total amount of payments made to the State for fiscal year 2010 under section 1903(a) of the Social Security Act (42 U.S.C. 1396b(a)) for purposes of carrying out a grant awarded under this section. Amounts paid to a State pursuant to this subsection shall remain available until expended.

''(2) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for any fiscal year such sums as may be necessary for purposes of making payments to States pursuant to paragraph (1).''.

TITLE VII—PROMOTING HEALTH INFORMATION TECHNOLOGY

Subtitle A—Assisting the Development of Health Information Technology

SEC. 701. PURPOSE.

It is the purpose of this subtitle to promote the utilization of health record banking by improving the coordination of health information through an infrastructure for the secure and authorized exchange and use of healthcare information.

SEC. 702. HEALTH RECORD BANKING.

(a) ESTABLISHMENT.—Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services shall promulgate regulations to provide for the certification and auditing of the banking of electronic medical records.

(b) GENERAL RIGHTS.—An individual who has a health record contained in a health record bank shall maintain ownership over the health record and shall have the right to review the contents of the record.

SEC. 703. APPLICATION OF FEDERAL AND STATE SECURITY AND CONFIDENTIALITY STANDARDS.

(a) IN GENERAL.—Current Federal security and confidentiality standards and State security and confidentiality laws shall apply to this subtitle until such time as Congress acts to amend such standards.

(b) DEFINITIONS.—In this section:

(1) CURRENT FEDERAL SECURITY AND CONFIDENTIALITY STANDARDS.—The term ''current Federal security and confidentiality standards'' means the Federal privacy standards established pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note) and security standards established under section 1173(d) of the Social Security Act (42 U.S.C. 1320d–2(d)).

(2) STATE SECURITY AND CONFIDENTIALITY LAWS.—The term ''State security and confidentiality laws'' means State laws and regulations relating to the privacy and confidentiality of individually identifiable health information or to the security of such information.

(3) STATE.—The term ''State'' has the meaning given such term for purposes of title XI of the Social Security Act, as provided under section 1101(a) of such Act (42 U.S.C. 1301(a)).

Subtitle B—Removing Barriers to the Use of Health Information Technology to Better Coordinate Health Care

SEC. 711. SAFE HARBORS TO ANTIKICKBACK CIVIL PENALTIES AND CRIMINAL PENALTIES FOR PROVISION OF HEALTH INFORMATION TECHNOLOGY AND TRAINING SERVICES.

(a) FOR CIVIL PENALTIES.—Section 1128A of the Social Security Act (42 U.S.C. 1320a–7a) is amended—

(1) in subsection (b), by adding at the end the following new paragraph:

''(4) For purposes of this subsection, inducements to reduce or limit services described in paragraph (1) shall not include the practical or other advantages resulting from health information technology or related installation, maintenance, support, or training services.''; and

(2) in subsection (i), by adding at the end the following new paragraph:

''(8) The term 'health information technology' means hardware, software, license, right, intellectual property, equipment, or other information technology (including new versions, upgrades, and connectivity) designed or provided primarily for the electronic creation, maintenance, or exchange of health information to better coordinate care or improve health care quality, efficiency, or research.''.

(b) FOR CRIMINAL PENALTIES.—Section 1128B of such Act (42 U.S.C. 1320a–7b) is amended—

(1) in subsection (b)(3)—

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

(B) in the subparagraph (H) added by section 237(d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2213)—

(i) by moving such subparagraph 2 ems to the left; and

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

(C) in the subparagraph (H) added by section 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) any nonmonetary remuneration (in the form of health information technology, as defined in section 1128A(i)(8), or related installation, maintenance, support or training services) made to a person by a specified entity (as defined in subsection (g)) if—

''(i) the provision of such remuneration is without an agreement between the parties or legal condition that—

''(I) limits or restricts the use of the health information technology to services provided by the physician to individuals receiving services at the specified entity;

''(II) limits or restricts the use of the health information technology in conjunction with other health information technology; or

''(III) conditions the provision of such remuneration on the referral of patients or business to the specified entity;

''(ii) such remuneration is arranged for in a written agreement that is signed by the parties involved (or their representatives) and that specifies the remuneration solicited or received (or offered or paid) and states that the provision of such remuneration is made for the primary purpose of better coordination of care or improvement of health quality, efficiency, or research; and

''(iii) the specified entity providing the remuneration (or a representative of such entity) has not taken any action to disable any basic feature of any hardware or software component of such remuneration that would permit interoperability.''; and

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

''(g) SPECIFIED ENTITY DEFINED.—For purposes of subsection (b)(3)(J), the term 'specified entity' means an entity that is a hospital, group practice, prescription drug plan sponsor, a Medicare Advantage organization, or any other such entity specified by the

Secretary, considering the goals and objectives of this section, as well as the goals to better coordinate the delivery of health care and to promote the adoption and use of health information technology.''.

(c) EFFECTIVE DATE AND EFFECT ON STATE LAWS.—

(1) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall take effect on the date that is 120 days after the date of the enactment of this Act.

(2) PREEMPTION OF STATE LAWS.—No State (as defined in section 1101(a) of the Social Security Act (42 U.S.C. 1301(a)) for purposes of title XI of such Act) shall have in effect a State law that imposes a criminal or civil penalty for a transaction described in section 1128A(b)(4) or section 1128B(b)(3)(J) of such Act, as added by subsections (a)(1) and (b), respectively, if the conditions described in the respective provision, with respect to such transaction, are met.

(d) STUDY AND REPORT TO ASSESS EFFECT OF SAFE HARBORS ON HEALTH SYSTEM.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall conduct a study to determine the impact of each of the safe harbors described in paragraph (3). In particular, the study shall examine the following:

(A) The effectiveness of each safe harbor in increasing the adoption of health information technology.

(B) The types of health information technology provided under each safe harbor.

(C) The extent to which the financial or other business relationships between providers under each safe harbor have changed as a result of the safe harbor in a way that adversely affects or benefits the health care system or choices available to consumers.

(D) The impact of the adoption of health information technology on health care quality, cost, and access under each safe harbor.

(2) REPORT.—Not later than 3 years after the effective date described in subsection (c)(1), the Secretary of Health and Human Services shall submit to Congress a report on the study under paragraph (1).

(3) SAFE HARBORS DESCRIBED.—For purposes of paragraphs (1) and (2), the safe harbors described in this paragraph are—

(A) the safe harbor under section 1128A(b)(4) of such Act (42 U.S.C. 1320a–7a(b)(4)), as added by subsection (a)(1); and

(B) the safe harbor under section 1128B(b)(3)(J) of such Act (42 U.S.C. 1320a–7b(b)(3)(J)), as added by subsection (b).

SEC. 712. EXCEPTION TO LIMITATION ON CERTAIN PHYSICIAN REFERRALS (UNDER STARK) FOR PROVISION OF HEALTH INFORMATION TECHNOLOGY AND TRAINING SERVICES TO HEALTH CARE PROFESSIONALS.

(a) IN GENERAL.—Section 1877(b) of the Social Security Act (42 U.S.C. 1395nn(b)) is amended by adding at the end the following new paragraph:

''(6) INFORMATION TECHNOLOGY AND TRAINING SERVICES.—

''(A) IN GENERAL.—Any nonmonetary remuneration (in the form of health information technology or related installation, maintenance, support or training services) made by a specified entity to a physician if—

''(i) the provision of such remuneration is without an agreement between the parties or legal condition that—

''(I) limits or restricts the use of the health information technology to services provided by the physician to individuals receiving services at the specified entity;

''(II) limits or restricts the use of the health information technology in conjunction with other health information technology; or

''(III) conditions the provision of such remuneration on the referral of patients or business to the specified entity;

''(ii) such remuneration is arranged for in a written agreement that is signed by the parties involved (or their representatives) and that specifies the remuneration made and states that the provision of such remuneration is made for the primary purpose of better coordination of care or improvement of health quality, efficiency, or research; and

''(iii) the specified entity (or a representative of such entity) has not taken any action to disable any basic feature of any hardware or software component of such remuneration that would permit interoperability.

''(B) HEALTH INFORMATION TECHNOLOGY DEFINED.—For purposes of this paragraph, the term 'health information technology' means hardware, software, license, right, intellectual property, equipment, or other information technology (including new versions, upgrades, and connectivity) designed or provided primarily for the electronic creation, maintenance, or exchange of health information to better coordinate care or improve health care quality, efficiency, or research.

''(C) SPECIFIED ENTITY DEFINED.—For purposes of this paragraph, the term 'specified entity' means an entity that is a hospital, group practice, prescription drug plan sponsor, a Medicare Advantage organization, or any other such entity specified by the Secretary, considering the goals and objectives of this section, as well as the goals to better coordinate the delivery of health care and to promote the adoption and use of health information technology.''.

(b) EFFECTIVE DATE; EFFECT ON STATE LAWS.—

(1) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date that is 120 days after the date of the enactment of this Act.

(2) PREEMPTION OF STATE LAWS.—No State (as defined in section 1101(a) of the Social Security Act (42 U.S.C. 1301(a)) for purposes of title XI of such Act) shall have in effect a State law that imposes a criminal or civil penalty for a transaction described in section 1877(b)(6) of such Act, as added by subsection (a), if the conditions described in such section, with respect to such transaction, are met.

(c) STUDY AND REPORT TO ASSESS EFFECT OF EXCEPTION ON HEALTH SYSTEM.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall conduct a study to determine the impact of the exception under section 1877(b)(6) of such Act (42 U.S.C. 1395nn(b)(6)), as added by subsection (a). In particular, the study shall examine the following:

(A) The effectiveness of the exception in increasing the adoption of health information technology.

(B) The types of health information technology provided under the exception.

(C) The extent to which the financial or other business relationships between providers under the exception have changed as a result of the exception in a way that adversely affects or benefits the health care system or choices available to consumers.

(D) The impact of the adoption of health information technology on health care quality, cost, and access under the exception.

(2) REPORT.—Not later than 3 years after the effective date described in subsection (b)(1), the Secretary of Health and Human Services shall submit to Congress a report on the study under paragraph (1).

SEC. 713. RULES OF CONSTRUCTION REGARDING USE OF CONSORTIA.

(a) APPLICATION TO SAFE HARBOR FROM CRIMINAL PENALTIES.—Section 1128B(b)(3) of the Social Security Act (42 U.S.C. 1320a–7b(b)(3)) is amended by adding after and below subparagraph (J), as added by section 711(b)(1), the following: ''For purposes of subparagraph (J), nothing in such subparagraph shall be construed as preventing a specified entity, consistent with the specific requirements of such subparagraph, from forming a consortium composed of health care providers, payers, employers, and other interested entities to collectively purchase and donate health information technology, or from offering health care providers a choice of health information technology products in order to take into account the varying needs of such providers receiving such products.''.

(b) APPLICATION TO STARK EXCEPTION.—Paragraph (6) of section 1877(b) of the Social Security Act (42 U.S.C. 1395nn(b)), as added by section 712(a), is amended by adding at the end the following new subparagraph:

''(D) RULE OF CONSTRUCTION.—For purposes of subparagraph (A), nothing in such subparagraph shall be construed as preventing a specified entity, consistent with the specific requirements of such subparagraph, from—

''(i) forming a consortium composed of health care providers, payers, employers, and other interested entities to collectively purchase and donate health information technology; or

''(ii) offering health care providers a choice of health information technology products in order to take into account the varying needs of such providers receiving such products.''.

TITLE VIII—HEALTH CARE SERVICES COMMISSION

Subtitle A—Establishment and General Duties

SEC. 801. ESTABLISHMENT.

(a) IN GENERAL.—There is hereby established a Health Care Services Commission (in this title, referred to as the ''Commission'') to be composed of 5 commissioners (in this title referred to as the ''Commissioners'') to be appointed by the President by and with the advice and consent of the Senate. Not more than 3 of such Commissioners shall be members of the same political party, and in making appointments members of different political parties shall be appointed alternately as nearly as may be practicable. No Commissioner shall engage in any other business, vocation, or employment than that of serving as Commissioner. Each Commissioner shall hold office for a term of 5 years and until a successor is appointed and has qualified, except that—

(1) such Commissioner shall not so continue to serve beyond the expiration of the next session of Congress subsequent to the expiration of said fixed term of office;

(2) any Commissioner appointed to fill a vacancy occurring prior to the expiration of the term for which a predecessor was appointed shall be appointed for the remainder of such term; and

(3) the terms of office of the Commissioners first taking office after the date of the enactment of this Act shall expire as designated by the President at the time of nomination, 1 at the end of 1 year, 1 at the end of 2 years, 1 at the end of 3 years, 1 at the end of 4 years, and 1 at the end of 5 years, after the date of the enactment of this Act.

(b) PURPOSE.—The purpose of the Commission is to enhance the quality, appropriateness, and effectiveness of health care services, and access to such services, through the establishment of a broad base of scientific research and through the promotion of improvements in clinical practice and in the organization, financing, and delivery of health care services.

(c) APPOINTMENT OF CHAIRMAN.—The President shall, from among the Commissioners appointed under subsection (a), designate an individual to serve as the Chairman of the Commission.

SEC. 802. GENERAL AUTHORITIES AND DUTIES.

(a) IN GENERAL.—In carrying out section 801(b), the Commissioners shall conduct and

support research, demonstration projects, evaluations, training, guideline development, and the dissemination of information, on health care services and on systems for the delivery of such services, including activities with respect to—

(1) the effectiveness, efficiency, and quality of health care services;

(2) the outcomes of health care services and procedures;

(3) clinical practice, including primary care and practice-oriented research;

(4) health care technologies, facilities, and equipment;

(5) health care costs, productivity, and market forces;

(6) health promotion and disease prevention;

(7) health statistics and epidemiology; and

(8) medical liability.

(b) REQUIREMENTS WITH RESPECT TO RURAL AREAS AND UNDERSERVED POPULATIONS.—In carrying out subsection (a), the Commissioners shall undertake and support research, demonstration projects, and evaluations with respect to—

(1) the delivery of health care services in rural areas (including frontier areas); and

(2) the health of low-income groups, minority groups, and the elderly.

SEC. 803. DISSEMINATION.

(a) IN GENERAL.—The Commissioners shall—

(1) promptly publish, make available, and otherwise disseminate, in a form understandable and on as broad a basis as practicable so as to maximize its use, the results of research, demonstration projects, and evaluations conducted or supported under this title and the guidelines, standards, and review criteria developed under this title;

(2) promptly make available to the public data developed in such research, demonstration projects, and evaluations; and

(3) as appropriate, provide technical assistance to State and local government and health agencies and conduct liaison activities to such agencies to foster dissemination.

(b) PROHIBITION AGAINST RESTRICTIONS.—Except as provided in subsection (c), the Commissioners may not restrict the publication or dissemination of data from, or the results of, projects conducted or supported under this title.

(c) LIMITATION ON USE OF CERTAIN INFORMATION.—No information, if an establishment or person supplying the information or described in it is identifiable, obtained in the course of activities undertaken or supported under this title may be used for any purpose other than the purpose for which it was supplied unless such establishment or person has consented (as determined under regulations of the Secretary) to its use for such other purpose. Such information may not be published or released in other form if the person who supplied the information or who is described in it is identifiable unless such person has consented (as determined under regulations of the Secretary) to its publication or release in other form.

(d) CERTAIN INTERAGENCY AGREEMENT.—The Commissioners and the Director of the National Library of Medicine shall enter into an agreement providing for the implementation of subsection (a)(1).

Subtitle B—Forum for Quality and Effectiveness in Health Care

SEC. 811. ESTABLISHMENT OF OFFICE.

There is established within the Commission an office to be known as the Office of the Forum for Quality and Effectiveness in Health Care. The office shall be headed by a director (referred to in this title as the ''Director'') who shall be appointed by the Commissioners.

SEC. 812. MEMBERSHIP.

(a) IN GENERAL.—The Office of the Forum for Quality and Effectiveness in Health Care shall be composed of 15 individuals nominated by private sector health care organizations and appointed by the Commission and shall include representation from at least the following:

(1) Health insurance industry.

(2) Health care provider groups.

(3) Non-profit organizations.

(4) Rural health organizations.

(b) TERMS.—

(1) IN GENERAL.—Except as provided in paragraph (2), members of the Office of the Forum for Quality and Effectiveness in Health Care shall serve for a term of 5 years.

(2) STAGGERED ROTATION.—Of the members first appointed to the Office of the Forum for Quality and Effectiveness in Health Care, the Commission shall appoint 5 members to serve for a term of 2 years, 5 members to serve for a term of 3 years, and 5 members to serve for a term of 4 years.

(c) TREATMENT OF OTHER EMPLOYMENT.—Each member of the Office of the Forum for Quality and Effectiveness in Health Care shall serve the Office independently from any other position of employment.

SEC. 813. DUTIES.

(a) ESTABLISHMENT OF FORUM PROGRAM.—The Commissioners, acting through the Director, shall establish a program to be known as the Forum for Quality and Effectiveness in Health Care. For the purpose of promoting transparency in price, quality, appropriateness, and effectiveness of health care, the Director, using the process set forth in section 814, shall arrange for the development and periodic review and updating of standards of quality, performance measures, and medical review criteria through which health care providers and other appropriate entities may assess or review the provision of health care and assure the quality of such care.

(b) CERTAIN REQUIREMENTS.—Guidelines, standards, performance measures, and review criteria under subsection (a) shall—

(1) be based on the best available research and professional judgment regarding the effectiveness and appropriateness of health care services and procedures; and

(2) be presented in formats appropriate for use by physicians, health care practitioners, providers, medical educators, and medical review organizations and in formats appropriate for use by consumers of health care.

(c) AUTHORITY FOR CONTRACTS.—In carrying out this subtitle, the Director may enter into contracts with public or nonprofit private entities.

(d) PUBLIC DISCLOSURE OF RECOMMENDATIONS.—For each fiscal year beginning with 2010, the Director shall make publicly available the following:

(1) Quarterly reports for public comment that include proposed recommendations for guidelines, standards, performance measures, and review criteria under subsection (a) and any updates to such guidelines, standards, performance measures, and review criteria.

(2) After consideration of such comments, a final report that contains final recommendations for such guidelines, standards, performance measures, review criteria, and updates.

(e) DATE CERTAIN FOR INITIAL GUIDELINES AND STANDARDS.—The Commissioners, by not later than January 1, 2012, shall assure the development of an initial set of guidelines, standards, performance measures, and review criteria under subsection (a).

SEC. 814. ADOPTION AND ENFORCEMENT OF GUIDELINES AND STANDARDS.

(a) ADOPTION OF RECOMMENDATIONS OF FORUM FOR QUALITY AND EFFECTIVENESS IN HEALTH CARE.—For each fiscal year, the Commissioners shall adopt the recommendations made for such year in the final report under subsection (d)(2) of section 813 for guidelines, standards, performance measures, and review criteria described in subsection (a) of such section.

(b) ENFORCEMENT AUTHORITY.—The Commissioners, in consultation with the Secretary of Health and Human Services, have the authority to make recommendations to the Secretary to enforce compliance of health care providers with the guidelines, standards, performance measures, and review criteria adopted under subsection (a). Such recommendations may include the following, with respect to a health care provider who is not in compliance with such guidelines, standards, measures, and criteria:

(1) Exclusion from participation in Federal health care programs (as defined in section 1128B(f) of the Social Security Act (42 U.S.C. 1320a–7b(f))).

(2) Imposition of a civil money penalty on such provider.

SEC. 815. ADDITIONAL REQUIREMENTS.

(a) PROGRAM AGENDA.—The Commissioners shall provide for an agenda for the development of the guidelines, standards, performance measures, and review criteria described in section 813(a), including with respect to the standards, performance measures, and review criteria, identifying specific aspects of health care for which the standards, performance measures, and review criteria are to be developed and those that are to be given priority in the development of the standards, performance measures, and review criteria.

Subtitle C—General Provisions

SEC. 821. CERTAIN ADMINISTRATIVE AUTHORITIES.

The Commissioners, in carrying out this title, may accept voluntary and uncompensated services.

SEC. 822. FUNDING.

For the purpose of carrying out this title, there are authorized to be appropriated such sums as may be necessary for fiscal years 2010 through 2014.

SEC. 823. DEFINITIONS.

For purposes of this title:

(1) The term ''Commissioners'' means the Commissioners of the Health Care Services Commission.

(2) The term ''Commission'' means the Health Care Services Commission.

(3) The term ''Director'' means the Director of the Office of the Forum for Quality and Effectiveness in Health Care.

(4) The term ''Secretary'' means the Secretary of Health and Human Services.

Subtitle D—Terminations and Transition

SEC. 831. TERMINATION OF AGENCY FOR HEALTHCARE RESEARCH AND QUALITY.

As of the date of the enactment of this Act, the Agency for Healthcare Research and Quality is terminated, and title IX of the Public Health Service Act is repealed.

SEC. 832. TRANSITION.

All orders, grants, contracts, privileges, and other determinations or actions of the Agency for Healthcare Research and Quality that are effective as of the date before the date of the enactment of this Act, shall be transferred to the Secretary and shall continue in effect according to their terms unless changed pursuant to law.

Subtitle E—Independent Health Record Trust

SEC. 841. SHORT TITLE.

This subtitle may be cited as the ''Independent Health Record Trust Act of 2009''.

SEC. 842. PURPOSE.

It is the purpose of this subtitle to provide for the establishment of a nationwide health information technology network that—

(1) improves health care quality, reduces medical errors, increases the efficiency of care, and advances the delivery of appropriate, evidence-based health care services;

(2) promotes wellness, disease prevention, and the management of chronic illnesses by increasing the availability and transparency of information related to the health care needs of an individual;

(3) ensures that appropriate information necessary to make medical decisions is available in a usable form at the time and in the location that the medical service involved is provided;

(4) produces greater value for health care expenditures by reducing health care costs that result from inefficiency, medical errors, inappropriate care, and incomplete information;

(5) promotes a more effective marketplace, greater competition, greater systems analysis, increased choice, enhanced quality, and improved outcomes in health care services;

(6) improves the coordination of information and the provision of such services through an effective infrastructure for the secure and authorized exchange and use of health information; and

(7) ensures that the health information privacy, security, and confidentiality of individually identifiable health information is protected.

SEC. 843. DEFINITIONS.

In this subtitle:

(1) ACCESS.—The term ''access'' means, with respect to an electronic health record, entering information into such account as well as retrieving information from such account.

(2) ACCOUNT.—The term ''account'' means an electronic health record of an individual contained in an independent health record trust.

(3) AFFIRMATIVE CONSENT.—The term ''affirmative consent'' means, with respect to an electronic health record of an individual contained in an IHRT, express consent given by the individual for the use of such record in response to a clear and conspicuous request for such consent or at the individual's own initiative.

(4) AUTHORIZED EHR DATA USER.—The term ''authorized EHR data user'' means, with respect to an electronic health record of an IHRT participant contained as part of an IHRT, any entity (other than the participant) authorized (in the form of affirmative consent) by the participant to access the electronic health record.

(5) CONFIDENTIALITY.—The term ''confidentiality'' means, with respect to individually identifiable health information of an individual, the obligation of those who receive such information to respect the health information privacy of the individual.

(6) ELECTRONIC HEALTH RECORD.—The term ''electronic health record'' means a longitudinal collection of information concerning a single individual, including medical records and personal health information, that is stored electronically.

(7) HEALTH INFORMATION PRIVACY.—The term ''health information privacy'' means, with respect to individually identifiable health information of an individual, the right of such individual to control the acquisition, uses, or disclosures of such information.

(8) HEALTH PLAN.—The term ''health plan'' means a group health plan (as defined in section 2208(1) of the Public Health Service Act (42 U.S.C. 300bb–8(1))) as well as a plan that offers health insurance coverage in the individual market.

(9) HIPAA PRIVACY REGULATIONS.—The term ''HIPAA privacy regulations'' means the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note).

(10) INDEPENDENT HEALTH RECORD TRUST; IHRT.—The terms ''independent health record trust'' and ''IHRT'' mean a legal arrangement under the administration of an IHRT operator that meets the requirements of this subtitle with respect to electronic health records of individuals participating in the trust or IHRT.

(11) IHRT OPERATOR.—The term ''IHRT operator'' means, with respect to an IHRT, the organization that is responsible for the administration and operation of the IHRT in accordance with this subtitle.

(12) IHRT PARTICIPANT.—The term ''IHRT participant'' means, with respect to an IHRT, an individual who has a participation agreement in effect with respect to the maintenance of the individual's electronic health record by the IHRT.

(13) INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.—The term ''individually identifiable health information'' has the meaning given such term in section 1171(6) of the Social Security Act (42 U.S.C. 1320d(6)).

(14) SECURITY.—The term ''security'' means, with respect to individually identifiable health information of an individual, the physical, technological, or administrative safeguards or tools used to protect such information from unwarranted access or disclosure.

SEC. 844. ESTABLISHMENT, CERTIFICATION, AND MEMBERSHIP OF INDEPENDENT HEALTH RECORD TRUSTS.

(a) ESTABLISHMENT.—Not later than one year after the date of the enactment of this Act, the Federal Trade Commission, in consultation with the National Committee on Vital and Health Statistics, shall prescribe standards for the establishment, certification, operation, and interoperability of IHRTs to carry out the purposes described in section 842 in accordance with the provisions of this subtitle.

(b) CERTIFICATION.—

(1) CERTIFICATION BY FTC.—The Federal Trade Commission shall provide for the certification of IHRTs. No IHRT may be certified unless the IHRT is determined to meet the standards for certification established under subsection (a).

(2) DECERTIFICATION.—The Federal Trade Commission shall establish a process for the revocation of certification of an IHRT under this section in the case that the IHRT violates the standards established under subsection (a).

(c) MEMBERSHIP.—

(1) IN GENERAL.—To be eligible to be a participant in an IHRT, an individual shall—

(A) submit to the IHRT information as required by the IHRT to establish an electronic health record with the IHRT; and

(B) enter into a privacy protection agreement described in section 846(b)(1) with the IHRT.

The process to determine eligibility of an individual under this subsection shall allow for the establishment by such individual of an electronic health record as expeditiously as possible if such individual is determined so eligible.

(2) NO LIMITATION ON MEMBERSHIP.—Nothing in this subsection shall be construed to permit an IHRT to restrict membership, including on the basis of health condition.

SEC. 845. DUTIES OF IHRT TO IHRT PARTICIPANTS.

(a) FIDUCIARY DUTY OF IHRT; PENALTIES FOR VIOLATIONS OF FIDUCIARY DUTY.—

(1) FIDUCIARY DUTY.—With respect to the electronic health record of an IHRT participant maintained by an IHRT, the IHRT shall have a fiduciary duty to act for the benefit and in the interests of such participant and of the IHRT as a whole. Such duty shall include obtaining the affirmative consent of such participant prior to the release of information in such participant's electronic health record in accordance with the requirements of this subtitle.

(2) PENALTIES.—If the IHRT knowingly or recklessly breaches the fiduciary duty described in paragraph (1), the IHRT shall be subject to the following penalties:

(A) Loss of certification of the IHRT.

(B) A fine that is not in excess of $50,000.

(C) A term of imprisonment for the individuals involved of not more than 5 years.

(b) ELECTRONIC HEALTH RECORD DEEMED TO BE HELD IN TRUST BY IHRT.—With respect to an individual, an electronic health record maintained by an IHRT shall be deemed to be held in trust by the IHRT for the benefit of the individual and the IHRT shall have no legal or equitable interest in such electronic health record.

SEC. 846. AVAILABILITY AND USE OF INFORMATION FROM RECORDS IN IHRT CONSISTENT WITH PRIVACY PROTECTIONS AND AGREEMENTS.

(a) PROTECTED ELECTRONIC HEALTH RECORDS USE AND ACCESS.—

(1) GENERAL RIGHTS REGARDING USES OF INFORMATION.—

(A) IN GENERAL.—With respect to the electronic health record of an IHRT participant maintained by an IHRT, subject to paragraph (2)(C), primary uses and secondary uses (described in subparagraphs (B) and (C), respectively) of information within such record (other than by such participant) shall be permitted only upon the authorization of such use, prior to such use, by such participant.

(B) PRIMARY USES.—For purposes of subparagraph (A) and with respect to an electronic health record of an individual, a primary use is a use for purposes of the individual's self-care or care by health care professionals.

(C) SECONDARY USES.—For purposes of subparagraph (B) and with respect to an electronic health record of an individual, a secondary use is any use not described in subparagraph (B) and includes a use for purposes of public health research or other related activities. Additional authorization is required for a secondary use extending beyond the original purpose of the secondary use authorized by the IHRT participant involved. Nothing in this paragraph shall be construed as requiring authorization for every secondary use that is within the authorized original purpose.

(2) RULES FOR PRIMARY USE OF RECORDS FOR HEALTH CARE PURPOSES.—With respect to the electronic health record of an IHRT participant (or specified parts of such electronic health record) maintained by an IHRT standards for access to such record shall provide for the following:

(A) ACCESS BY IHRT PARTICIPANTS TO THEIR ELECTRONIC HEALTH RECORDS.—

(i) OWNERSHIP.—The participant maintains ownership over the entire electronic health record (and all portions of such record) and shall have the right to electronically access and review the contents of the entire record (and any portion of such record) at any time, in accordance with this subparagraph.

(ii) ADDITION OF PERSONAL INFORMATION.—The participant may add personal health information to the health record of that participant, except that such participant shall not alter information that is entered into the electronic health record by any authorized EHR data user. Such participant shall have the right to propose an amendment to information that is entered by an authorized EHR data user pursuant to standards prescribed by the Federal Trade Commission for purposes of amending such information.

(iii) IDENTIFICATION OF INFORMATION ENTERED BY PARTICIPANT.—Any additions or amendments made by the participant to the health record shall be identified and disclosed within such record as being made by such participant.

(B) ACCESS BY ENTITIES OTHER THAN IHRT PARTICIPANT.—

(i) AUTHORIZED ACCESS ONLY.—Except as provided under subparagraph (C) and paragraph (4), access to the electronic health record (or any portion of the record)—

(I) may be made only by authorized EHR data users and only to such portions of the record as specified by the participant; and

(II) may be limited by the participant for purposes of entering information into such record, retrieving information from such record, or both.

(ii) IDENTIFICATION OF ENTITY THAT ENTERS INFORMATION.—Any information that is added by an authorized EHR data user to the health record shall be identified and disclosed within such record as being made by such user.

(iii) SATISFACTION OF HIPAA PRIVACY REGULATIONS.—In the case of a record of a covered entity (as defined for purposes of HIPAA privacy regulations), with respect to an individual, if such individual is an IHRT participant with an independent health record trust and such covered entity is an authorized EHR data user, the requirement under the HIPAA privacy regulations for such entity to provide the record to the participant shall be deemed met if such entity, without charge to the IHRT or the participant—

(I) forwards to the trust an appropriately formatted electronic copy of the record (and updates to such records) for inclusion in the electronic health record of the participant maintained by the trust;

(II) enters such record into the electronic health record of the participant so maintained; or

(III) otherwise makes such record available for electronic access by the IHRT or the individual in a manner that permits such record to be included in the account of the individual contained in the IHRT.

(iv) NOTIFICATION OF SENSITIVE INFORMATION.—Any information, with respect to the participant, that is sensitive information, as specified by the Federal Trade Commission, shall not be forwarded or entered by an authorized EHR data user into the electronic health record of the participant maintained by the trust unless the user certifies that the participant has been notified of such information.

(C) DEEMED AUTHORIZATION FOR ACCESS FOR EMERGENCY HEALTH CARE.—

(i) FINDINGS.—Congress finds that—

(I) given the size and nature of visits to emergency departments in the United States, readily available health information could make the difference between life and death; and

(II) because of the case mix and volume of patients treated, emergency departments are well positioned to provide information for public health surveillance, community risk assessment, research, education, training, quality improvement, and other uses.

(ii) USE OF INFORMATION.—With respect to the electronic health record of an IHRT participant (or specified parts of such electronic health record) maintained by an IHRT, the participant shall be deemed as providing authorization (in the form of affirmative consent) for health care providers to access, in connection with providing emergency care services to the participant, a limited, authenticated information set concerning the participant for emergency response purposes, unless the participant specifies that such information set (or any portion of such information set) may not be so accessed. Such limited information set may include information—

(I) patient identification data, as determined appropriate by the participant;

(II) provider identification that includes the use of unique provider identifiers;

(III) payment information;

(IV) information related to the individual's vitals, allergies, and medication history;

(V) information related to existing chronic problems and active clinical conditions of the participant; and

(VI) information concerning physical examinations, procedures, results, and diagnosis data.

(3) RULES FOR SECONDARY USES OF RECORDS FOR RESEARCH AND OTHER PURPOSES.—

(A) IN GENERAL.—With respect to the electronic health record of an IHRT participant (or specified parts of such electronic health record) maintained by an IHRT, the IHRT may sell such record (or specified parts of such record) only if—

(i) the transfer is authorized by the participant pursuant to an agreement between the participant and the IHRT and is in accordance with the privacy protection agreement described in subsection (b)(1) entered into between such participant and such IHRT;

(ii) such agreement includes parameters with respect to the disclosure of information involved and a process for the authorization of the further disclosure of information in such record;

(iii) the information involved is to be used for research or other activities only as provided for in the agreement;

(iv) the recipient of the information provides assurances that the information will not be further transferred or reused in violation of such agreement; and

(v) the transfer otherwise meets the requirements and standards prescribed by the Federal Trade Commission.

(B) TREATMENT OF PUBLIC HEALTH REPORTING.—Nothing in this paragraph shall be construed as prohibiting or limiting the use of health care information of an individual, including an individual who is an IHRT participant, for public health reporting (or other research) purposes prior to the inclusion of such information in an electronic health record maintained by an IHRT.

(4) LAW ENFORCEMENT CLARIFICATION.—Nothing in this subtitle shall prevent an IHRT from disclosing information contained in an electronic health record maintained by the IHRT when required for purposes of a lawful investigation or official proceeding inquiring into a violation of, or failure to comply with, any criminal or civil statute or any regulation, rule, or order issued pursuant to such a statute.

(5) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to require a health care provider that does not utilize electronic methods or appropriate levels of health information technology on the date of the enactment of this Act to adopt such electronic methods or technology as a requirement for participation or compliance under this subtitle.

(b) PRIVACY PROTECTION AGREEMENT; TREATMENT OF STATE PRIVACY AND SECURITY LAWS.—

(1) PRIVACY PROTECTION AGREEMENT.—A privacy protection agreement described in this subsection is an agreement, with respect to an electronic health record of an IHRT participant to be maintained by an independent health record trust, between the participant and the trust—

(A) that is consistent with the standards described in subsection (a)(2);

(B) under which the participant specifies the portions of the record that may be accessed, under what circumstances such portions may be accessed, any authorizations for indicated authorized EHR data users to access information contained in the record, and the purposes for which the information (or portions of the information) in the record may be used;

(C) which provides a process for the authorization of the transfer of information contained in the record to a third party, including for the sale of such information for purposes of research, by an authorized EHR data user and reuse of such information by such third party, including a provision requiring that such transfer and reuse is not in violation of any privacy or transfer restrictions placed by the participant on the independent health record of such participant; and

(D) under which the trust provides assurances that the trust will not transfer, disclose, or provide access to the record (or any portion of the record) in violation of the parameters established in the agreement or to any person or entity who has not agreed to use and transfer such record (or portion of such record) in accordance with such agreement.

(2) TREATMENT OF STATE LAWS.—

(A) IN GENERAL.—Except as provided under subparagraph (B), the provisions of a privacy protection agreement entered into between an IHRT and an IHRT participant shall preempt any provision of State law (or any State regulation) relating to the privacy and confidentiality of individually identifiable health information or to the security of such health information.

(B) EXCEPTION FOR PRIVILEGED INFORMATION.—The provisions of a privacy protection agreement shall not preempt any provision of State law (or any State regulation) that recognizes privileged communications between physicians, health care practitioners, and patients of such physicians or health care practitioners, respectively.

(C) STATE DEFINED.—For purposes of this section, the term ''State'' has the meaning given such term when used in title XI of the Social Security Act, as provided under section 1101(a) of such Act (42 U.S.C. 1301(a)).

SEC. 847. VOLUNTARY NATURE OF TRUST PARTICIPATION AND INFORMATION SHARING.

(a) IN GENERAL.—Participation in an independent health record trust, or authorizing access to information from such a trust, is voluntary. No employer, health insurance issuer, group health plan, health care provider, or other person may require, as a condition of employment, issuance of a health insurance policy, coverage under a group health plan, the provision of health care services, payment for such services, or otherwise, that an individual participate in, or authorize access to information from, an independent health record trust.

(b) ENFORCEMENT.—The penalties provided for in subsection (a) of section 1177 of the Social Security Act (42 U.S.C. 1320d–6) shall apply to a violation of subsection (a) in the same manner as such penalties apply to a person in violation of subsection (a) of such section.

SEC. 848. FINANCING OF ACTIVITIES.

(a) IN GENERAL.—Except as provided in subsection (b), an IHRT may generate revenue to pay for the operations of the IHRT through—

(1) charging IHRT participants account fees for use of the trust;

(2) charging authorized EHR data users for accessing electronic health records maintained in the trust;

(3) the sale of information contained in the trust (as provided for in section 846(a)(3)(A)); and

(4) any other activity determined appropriate by the Federal Trade Commission.

(b) PROHIBITION AGAINST ACCESS FEES FOR HEALTH CARE PROVIDERS.—For purposes of providing incentives to health care providers to access information maintained in an IHRT, as authorized by the IHRT participants involved, the IHRT may not charge a fee for services specified by the IHRT. Such services shall include the transmittal of information from a health care provider to be included in an independent electronic health record maintained by the IHRT (or permitting such provider to input such information into the record), including the transmission of or access to information described in section 846(a)(2)(C)(ii) by appropriate emergency responders.

(c) REQUIRED DISCLOSURES.—The sources and amounts of revenue derived under subsection (a) for the operations of an IHRT shall be fully disclosed to each IHRT participant of such IHRT and to the public.

(d) TREATMENT OF INCOME.—For purposes of the Internal Revenue Code of 1986, any revenue described in subsection (a) shall not be included in gross income of any IHRT, IHRT participant, or authorized EHR data user.

SEC. 849. REGULATORY OVERSIGHT.

(a) IN GENERAL.—In carrying out this subtitle, the Federal Trade Commission shall promulgate regulations for independent health record trusts.

(b) ESTABLISHMENT OF INTERAGENCY STEERING COMMITTEE.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall establish an Interagency Steering Committee in accordance with this subsection.

(2) CHAIRPERSON.—The Secretary of Health and Human Services shall serve as the chairperson of the Interagency Steering Committee.

(3) MEMBERSHIP.—The members of the Interagency Steering Committee shall consist of the Attorney General, the Chairperson of the Federal Trade Commission, the Chairperson for the National Committee for Vital and Health Statistics, a representative of the Federal Reserve, and other Federal officials determined appropriate by the Secretary of Health and Human Services.

(4) DUTIES.—The Interagency Steering Committee shall coordinate the implementation of this title, including the implementation of policies described in subsection (d) based upon the recommendations provided under such subsection, and regulations promulgated under this subtitle.

(c) FEDERAL ADVISORY COMMITTEE.—

(1) IN GENERAL.—The National Committee for Vital and Health Statistics shall serve as an advisory committee for the IHRTs. The membership of such advisory committee shall include a representative from the Federal Trade Commission and the chairperson of the Interagency Steering Committee. Not less than 60 percent of such membership shall consist of representatives of nongovernment entities, at least one of whom shall be a representative from an organization representing health care consumers.

(2) DUTIES.—The National Committee for Vital and Health Statistics shall issue periodic reports and review policies concerning IHRTs based on each of the following factors:

(A) Privacy and security policies.

(B) Economic progress.

(C) Interoperability standards.

(d) POLICIES RECOMMENDED BY FEDERAL TRADE COMMISSION.—The Federal Trade Commission, in consultation with the National Committee for Vital and Health Statistics, shall recommend policies to—

(1) provide assistance to encourage the growth of independent health record trusts;

(2) track economic progress as it pertains to operators of independent health records trusts and individuals receiving nontaxable income with respect to accounts;

(3) conduct public education activities regarding the creation and usage of the independent health records trusts;

(4) establish standards for the interoperability of health information technology to ensure that information contained in such record may be shared between the trust involved, the participant, and authorized EHR data users, including for the standardized collection and transmission of individual health records (or portions of such records) to authorized EHR data users through a common interface and for the portability of such records among independent health record trusts; and

(5) carry out any other activities determined appropriate by the Federal Trade Commission.

(e) REGULATIONS PROMULGATED BY FEDERAL TRADE COMMISSION.—The Federal Trade Commission shall promulgate regulations based on, at a minimum, the following factors:

(1) Requiring that an IHRT participant, who has an electronic health record that is maintained by an IHRT, be notified of a security breech with respect to such record, and any corrective action taken on behalf of the participant.

(2) Requiring that information sent to, or received from, an IHRT that has been designated as high-risk should be authenticated through the use of methods such as the periodic changing of passwords, the use of biometrics, the use of tokens or other technology as determined appropriate by the council.

(3) Requiring a delay in releasing sensitive health care test results and other similar information to patients directly in order to give physicians time to contact the patient.

(4) Recommendations for entities operating IHRTs, including requiring analysis of the potential risk of health transaction security breeches based on set criteria.

(5) The conduct of audits of IHRTs to ensure that they are in compliance with the requirements and standards established under this subtitle.

(6) Disclosure to IHRT participants of the means by which such trusts are financed, including revenue from the sale of patient data.

(7) Prevention of certification of an entity seeking independent heath record trust certification based on—

(A) the potential for conflicts between the interests of such entity and the security of the health information involved; and

(B) the involvement of the entity in any activity that is contrary to the best interests of a patient.

(8) Prevention of the use of revenue sources that are contrary to a patient's interests.

(9) Public disclosure of audits in a manner similar to financial audits required for publicly traded stock companies.

(10) Requiring notification to a participating entity that the information contained in such record may not be representative of the complete or accurate electronic health record of such account holder.

(f) COMPLIANCE REPORT.—Not later than 1 year after the date of the enactment of this Act, and annually thereafter, the Commission 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 on compliance by and progress of independent health record trusts with this subtitle. Such report shall describe the following:

(1) The number of complaints submitted about independent health record trusts, which shall be divided by complaints related to security breaches, and complaints not related to security breaches, and may include other categories as the Interagency Steering Committee established under subsection (b) determines appropriate.

(2) The number of enforcement actions undertaken by the Commission against independent health record trusts in response to complaints under paragraph (1), which shall be divided by enforcement actions related to security breaches and enforcement actions not related to security breaches and may include other categories as the Interagency Steering Committee established under subsection (b) determines appropriate.

(3) The economic progress of the individual owner or institution operator as achieved through independent health record trust usage and existing barriers to such usage.

(4) The progress in security auditing as provided for by the Interagency Steering Committee council under subsection (b).

(5) The other core responsibilities of the Commission as described in subsection (a).

(g) INTERAGENCY MEMORANDUM OF UNDERSTANDING.—The Interagency Steering Committee shall ensure, through the execution of an interagency memorandum of understanding, that—

(1) regulations, rulings, and interpretations issued by Federal officials relating to the same matter over which 2 or more such officials have responsibility under this subtitle are administered so as to have the same effect at all times; and

(2) the memorandum provides for the coordination of policies related to enforcing the same requirements through such officials in order to have coordinated enforcement strategy that avoids duplication of enforcement efforts and assigns priorities in enforcement.

TITLE IX—MISCELLANEOUS

SEC. 901. HEALTH CARE CHOICE FOR VETERANS.

Beginning not later than 2 years after the date of the enactment of this Act, the Secretary of Veterans Affairs may—

(1) permit veterans, and survivors and dependents of veterans, who are eligible for health care and services under the laws administered by the Secretary to receive such care and services through such non-Department of Veterans Affairs providers and facilities as the Secretary may approve for purposes of this section; and

(2) pursuant to such procedures as the Secretary of Veteran Affairs shall prescribe for purposes of this section, make payments to such providers and facilities for the provision of such care and services to veterans, and such survivors and dependents, at such rates as the Secretary may specify in such procedures and in such manner so that the Secretary ensures that the aggregate payments made by the Secretary to such providers and facilities do not exceed the aggregate amounts which the Secretary would have paid for such care and services if this section had not been enacted.

SEC. 902. HEALTH CARE CHOICE FOR INDIANS.

(a) IN GENERAL.—Beginning not later than 2 years after the date of enactment of this Act, the Secretary of Health and Human Services shall—

(1) permit Indians who are eligible for health care and services under a health care program operated or financed by the Indian Health Service or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (and any such other individuals who are so eligible as the Secretary may specify), to receive such care and services through such non- Indian Health Service, Indian Tribe, Tribal Organization, or Urban Indian Organization providers and facilities as the Secretary shall approve for purposes of this section; and

(2) pursuant to such procedures as the Secretary of Health and Human Services shall

prescribe for purposes of this section, make payments to such providers and facilities for the provision of such care and services to Indians and individuals described in paragraph (1), at such rates as the Secretary shall specify in such procedures and in such manner so that the Secretary ensures that the aggregate payments made by the Secretary to such providers and facilities do not exceed the aggregate amounts which the Secretary would have paid for such care and services if this section had not been enacted.

(b) DEFINITIONS.—In this section, the terms ''Indian'', ''Indian Health Program'', ''Indian Tribe'', ''Tribal Organization'', and ''Urban Indian Organization'' have the meanings given those terms in section 4 of the Indian Health Care Improvement Act.

SEC. 903. TERMINATION OF FEDERAL COORDINATING COUNCIL FOR COMPARATIVE EFFECTIVENESS RESEARCH.

The Federal Coordinating Council for Comparative Effectiveness Research is hereby terminated and section 804 of the American Recovery and Reinvestment Act of 2009 establishing and funding such Council is hereby repealed.

SEC. 904. HHS AND GAO JOINT STUDY AND REPORT ON COSTS OF THE 5 MEDICAL CONDITIONS THAT HAVE THE GREATEST IMPACT.

(a) STUDY.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') and the Comptroller General of the United States (in this section referred to as the ''Comptroller General'') shall jointly conduct a study on the costs of the top 5 medical conditions facing the public which have the greatest impact in terms of morbidity, mortality, and financial cost. Such study shall include—

(1) current estimates as well as a ''generational score'' to capture the financial cost and health toll certain medical conditions will inflict on the baby boomer generation and on other individuals; and

(2) a careful review of certain medical conditions, including heart disease, obesity, diabetes, stroke, cancer, Alzheimers, and other medical conditions the Secretary and Comptroller General determine appropriate.

(b) REPORT.—Not later than 1 year after the date of enactment of this Act, the Secretary and the Comptroller General shall jointly 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 and the Comptroller General determine appropriate.

(c) TARGETING OF PREVENTION AND WELLNESS EFFORTS.—The Secretary shall target prevention and wellness efforts conducted under the provisions of and amendments made by this Act in order to combat medical conditions identified in the report submitted under subsection (b), including such medical conditions identified as the top 5 medical conditions facing the public which have the greatest impact in terms of morbidity, mortality, and financial cost as of or after the date of enactment of this Act.

SEC. 905. CONSCIENCE PROTECTION.

(a) IN GENERAL.—None of the funds made available in this Act (or an amendment made by this Act) may be made available to a Federal agency or program, or to a State or local government, if such agency, program, or government subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions.

(b) HEALTH CARE ENTITY.—In this section, the term ''health care entity'' shall include an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan.

SEC. 906. NONDISCRIMINATION ON ABORTION AND RESPECT FOR RIGHTS OF CONSCIENCE.

(a) NONDISCRIMINATION.—A Federal agency or program, and any State or local government, or institutional health care entity that receives Federal financial assistance under this Act (or an amendment made by this Act), shall not—

(1) subject any individual or institutional health care entity to discrimination; or

(2) require any health care entity that is established or regulated under this Act (or an amendment made by this Act) to subject any individual or institutional health care entity to discrimination;

on the basis that such health care entity does not provide, pay for, provide coverage of, or refer for abortions.

(b) DEFINITION.—In this section, the term ''health care entity'' includes an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, a plan sponsor, a health insurance issuer, a qualified health plan or issuer offering such a plan, or any other kind of health care facility, organization, or plan.

(c) ADMINISTRATION.—The Office for Civil Rights of the Department of Health and Human Services is designated to receive complaints of discrimination based on this section, and coordinate the investigation of such complaints.

SEC. 907. PROHIBITION ON GOVERNMENT ENTITIES USING COMPARATIVE EFFECTIVENESS RESEARCH FOR CERTAIN PURPOSES.

Comparative effectiveness research and clinical effectiveness research shall not be used by any government entity for payment, coverage, or treatment decisions based on costs. Nothing in the preceding sentence shall limit a physician or other health care provider from using reports and recommendations of a government entity when making decisions about the best treatment for an individual patient in an individual circumstance.

SEC. 908. SOLVENCY OF MEDICARE PROGRAM.

Any savings achieved under the Medicare program pursuant to the measures developed and implemented by the Secretary of Health and Human Services under this Act (or an amendment made by this Act) shall be reinvested into the Federal Hospital Insurance Trust Fund, as established under section 1817 of the Social Security Act (4218 U.S.C. 1395i), or the Federal Supplementary Medical Insurance Trust Fund, as established under section 1841 of such Act (42 U.S.C. 1395t).

SEC. 909. TO ENSURE PATIENTS RECEIVE DOCTOR RECOMMENDATIONS FOR PREVENTIVE HEALTH SERVICES, INCLUDING MAMMOGRAMS AND CERVICAL CANCER SCREENING, WITHOUT INTERFERENCE FROM GOVERNMENT OR INSURANCE COMPANY.

(a) IN GENERAL.—Notwithstanding any other provision of law, the Secretary of Health and Human Services shall not use any recommendation made by the United States Preventive Services Task Force to deny coverage of an item or service by a group health plan or health insurance issuer offering group or individual health insurance coverage or under a Federal health care program (as defined in section 1128B(f) of the Social Security Act (42 U.S.C.1320a–7b(f))) or private insurance.

(b) DETERMINATIONS OF BENEFITS COVERAGE.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall, in determining which preventive items and services to provide coverage for under the plan or coverage, consult the medical guidelines and recommendations of relevant professional medical organizations of relevant medical practice areas (such as the American Society of Clinical Oncology, the American College of Surgeons, the American College of Radiation Oncology, the American College of Obstetricians and Gynecologists, and other similar organizations), including guidelines and recommendations relating to the coverage of women's preventive services (such as mammograms and cervical cancer screenings).

SEC. 910. ENSURING THAT GOVERNMENT HEALTH CARE RATIONING DOES NOT HARM, INJURE, OR DENY MEDICALLY NECESSARY CARE.

Notwithstanding any other provision of law—

(1) no individual may be denied health care based on age or life expectancy by any Federal health program; and

(2) no entity of the Federal Government may develop Quality-Adjusted Life Year measures or other similarly designed government formulas based on an individual's social utility for limiting access to necessary medical treatment.

SEC. 911. IDENTIFICATION OF FEDERAL GOVERNMENT HEALTH CARE RATIONING.

(a) IN GENERAL.—The Comptroller General of the United States shall conduct, and submit to Congress a report describing the results of, a study that compares, with regard to the programs described in subsection (b)—

(1) any restrictions or limitations regarding access to health care providers (including the percentage of health care providers willing or permitted to care for patients insured by each program);

(2) any restrictions, denials, or rationing relating to the provision of health care, including medical procedures, tests (including mammograms and cervical cancer screenings), and prescription drug formularies;

(3) average wait times to see a primary care doctor;

(4) average wait times for medically necessary surgeries and medical procedures; and

(5) the estimated waste, fraud, and abuse (including improper payments) in each program.

(b) PROGRAMS.——The programs referred to in subsection (a) are—

(1) Medicare;

(2) Medicaid;

(3) the Indian Health Service;

(4) the Department of Veterans Affairs; and

(5) the Federal Employee Health Benefits Program.

SEC. 912. USING HEALTH CARE PROFESSIONALS TO REDUCE FRAUD.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary'' shall establish a demonstration project that uses practicing health care professionals to conduct undercover investigations of other health care professionals.

(b) DEMONSTRATION PROJECT.—

(1) IN GENERAL.—The Secretary, in coordination with the Office of the Inspector General of the Department of Health and Human Services (referred to in this section as the ''Inspector General''), shall establish a demonstration project in which the Secretary enters into contracts with practicing health care professionals to conduct investigations of health care providers that receive reimbursements through any Federal public health care program.

(2) SCOPE.—The Secretary shall conduct the demonstration project under this section in States or regions that have—

(A) above-average rates of Medicare fraud; or

(B) any level of Medicaid fraud.

(c) ELIGIBILITY.—To be eligible to receive a contract under subsection (b)(1), a health care professional shall—

(1) be a licensed and practicing medical professional who holds an advanced medical degree from an accredited American university or college and has experience within the health care industry; and

(2) submit to the Secretary such information, at such time, and in such manner, as the Secretary may require.

(d) ACTIVITIES.—Each health care professional awarded a contract under subsection (b)(1) shall assist the Secretary and the Inspector General in conducting random audits of the practices of health care providers that receive reimbursements through any Federal public health care program. Such audits may include—

(1) statistically random visits to the practices of such health care providers;

(2) attempts to purchase pharmaceutical products illegally from such health care providers;

(3) purchasing durable medical equipment from such health care providers;

(4) hospital visits; and

(5) other activities, as the Secretary determines appropriate.

(e) FOLLOW-UP BY THE INSPECTOR GENERAL.—The Inspector General shall follow up on any notable findings of the investigations conducted under subsection (d) in order to report fraudulent practices and refer individual cases to the appropriate State and local authorities.

(f) LIMITATION.—The Secretary shall not contract with a health care professional if, due to physical proximity or a personal, familial, proprietary, or monetary relationship with such health care professional to individuals that such professional would be investigating, a conflict of interest could be inferred.

(g) FUNDING.—To carry out this section, the Secretary and the Inspector General are each authorized to reserve, from amounts appropriated to the Department of Health and Human Services and the Office of the Inspector General of the Department of Health and Human Services, respectively, $500,000 for each of fiscal years 2010 through 2014.

ADJOURNMENT UNTIL 1 P.M. TOMORROW

The PRESIDING OFFICER. Under the previous order, the Senate stands adjourned until 1 p.m. tomorrow.

There upon the Senate, at 5:34 p.m., adjourned until Sunday, December 20, 2009, at 1 p.m.