The Senate met at 9:30 a.m. and was called to order by the Honorable MARK L. PRYOR, a Senator from the State of Arkansas.

PRAYER

The Chaplain, Dr. Barry C. Black, offered the following prayer:

Let us pray.

Here we are again, Lord, a people in need of Your presence and power in order to meet life with courage and faith.

Today, strengthen the Members of this body with a faith that will ever choose the harder right over the easy expedient. Give them wisdom to follow Your example of sacrificial service, infusing them with the courage to do right as You give them the light to see it. Lord, lift from them the burden of loss and sorrow when forces beyond their control invade their lives and seek to rob them of Your peace. Bless them with the assurance that they are never alone, for You have promised never to forsake them. Fill their disappointments with Your strengthening presence, transforming their darkness into the glory of Your new dawn of hope and life.

We pray in Your great Name. Amen.

PLEDGE OF ALLEGIANCE

The Honorable Mark L. Pryor led the Pledge of Allegiance, as follows:

I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

APPOINTMENT OF ACTING PRESIDENT PRO TEMPORE

The PRESIDING OFFICER. The clerk will please read a communication to the Senate from the President pro tempore (Mr. Byrd).

The legislative clerk read the following letter:

U.S. SENATE,
President pro tempore,

To the Senate:

Under the provisions of rule I, paragraph 3, of the Standing Rules of the Senate, I hereby appoint the Honorable Mark L. Pryor, a Senator from the State of Arkansas, to perform the duties of the Chair.

Robert C. Byrd, President pro tempore.

Mr. Pryor thereupon assumed the chair as Acting President pro tempore.

RECOGNITION OF THE MAJORITY LEADER

The ACTING PRESIDENT pro tempore. The majority leader is recognized.

Mr. Reid. Mr. President, I suggest the absence of a quorum.

The ACTING PRESIDENT pro tempore. The Clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. Reid. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

SCHEDULE

Mr. Reid. Mr. President, following leader remarks, the Senate will be in a period of morning business for an hour. Senators during that time will be permitted to speak for up to 10 minutes each. The majority will control the first 30 minutes and the Republicans will control the final 30 minutes.

Following morning business, the Senate will proceed to the consideration of S. 1963, which is the Caregivers and Veterans Omnibus Health Services Act. Debate on the bill will be limited to 30 minutes equally divided and controlled between Senators Akaka and Burr or their designees. The only amendment in order to the bill is the Coburn amendment relating to the funding priorities in this bill. Debate on the Coburn amendment is limited to 3 hours, with Senator Coburn controlling 2 hours and Senator Akaka controlling the final hour.

At 2 p.m., the Senate will resume debate on the nomination of David Hamilton to be U.S. circuit judge for the Seventh Circuit. Debate until 2:30 p.m. is going to be equally divided and controlled between Senators Leahy and Sessions or their designees.

After 2:30 p.m., the Senate will proceed to a series of three rollcall votes. Those votes will be on confirmation of the Hamilton nomination, in relation to the Coburn amendment, and on passage of the veterans omnibus bill.

HEALTH CARE REFORM

Mr. Reid. Mr. President, we have traveled a great distance to get where we stand today. With the bill we unveiled last night, we begin the last leg of this historic journey.

The American people and President Obama have asked us for health insurance reform. There are two things we must have above all: No. 1, make it more affordable for every American to live a healthy life, and No. 2, do so in a fiscally responsible way that helps our economy recover. Senate Democrats have listened, and we have written a bill that will save lives, save money, and save Medicare.

Since yesterday evening, the bill has been on the Internet for all to see. You will find it at democrats.senate.gov, but here is a quick summary of what is in that bill. And I say, Mr. President, this is a big bill. I was at a meeting with some other Senators this morning, and everyone acknowledged that no one can ever remember a bill that affects everybody in America as this bill does. It is a bill that has a lot of pages in it. But, as we know, it is printed the way all bills are printed. If we wanted to print it in smaller fashion—as books are written, for example—it
would be much smaller. It is a lot of words, and every word in it is important and necessary. Since yesterday evening, as I have indicated, this bill has been on the Internet. Everyone in the world can see this bill.

As the President asked us to do, this bill will not add a dime to the deficit—quite the opposite, in fact: It will cut by $120 billion in the first 10 years and by as much as $4 trillion in the first 20 years. We do this by keeping costs down. This critical reform will cost less than $85 billion a year over the next decade, well under President Obama’s goal.

We will make sure every American can afford quality health care. We will make sure more than 30 million Americans who do not have health care today will soon have it. We will not only protect Medicare, but we will make it stronger.

These numbers are as impressive as they are important for our Nation’s future, and though we are proud of these numbers, these figures, we owe not to overlook what this is really all about. More accurately, we cannot afford to overlook whom this is about.

This is about a parent who cannot take a child to the doctor because insurance is too expensive, their employer canceled it, or they lost their job. That is why we are making sure every American can afford good coverage.

This is about the small business in Nevada or someplace else in the country that had to lay off an employee because it couldn’t afford skyrocketing health care premiums. That is why we are cutting those small business taxes.

It is about the woman with high cholesterol or the man with heart disease or the child with hay fever who cannot get help and can’t get insurance. That is why we are stopping insurance companies from deciding they would rather not give health care to the sick.

This is about the family who has to make a terrible choice between their mortgage and their medications. When this bill passes, the only choice they will have to make is which insurance company offers them the best coverage. They will have the choice to make, and it is a good choice. The choice is, which best suits their family?

This is also about mothers and sisters and wives and daughters who cannot get the tests they need to detect breast cancer. It is inexcusable that women cannot get the tests they need. That is why we are making prevention and wellness a priority.

For these families and these businesses, for our economy’s renewal, our children’s future, and our Nation’s promise, the finish line is in sight. I am confident we will cross it soon. Once again, I am inviting my Republican colleagues to join us on the right side of history.

HEALTH CARE REFORM

Mr. McCONNEL. Mr. President, for months we have been warning the American people and Democrats’ plans to raise premiums, raise taxes, and slash Medicare in order to fund more government. Americans know that is not reform, and unfortunately the majority has not been listening.

While two committees have publicly reported legislation, the bill we are being asked to consider was assembled behind closed doors, out of sight, and with input from the public for over the last 6 weeks. We are being told we must rush to pass this legislation, even though most of its provisions will not take effect for another 5 years, until 2014. That is a little bit like being asked to pay your mortgage 4 years before you are allowed to move into your house. Americans deserve to know: How much will it cost? Will their premiums go up? What is hidden in the fine print? Are favored interests or States getting sweetheart deals? The American people want to take the time to get this right.

Over here, we have the House bill and the Senate bill together, each of them roughly 2,000 pages. You see this massive bill to rewrite one-sixth of our economy, with stunning unintended consequences for ourselves and for our children and for our grandchildren.

The majority leader’s bill is 2,074 pages long. When fully implemented—and the way to look at the true cost of this bill is how much it will cost over a 10-year period when it is fully implemented and in effect. In order to make it look less expensive, in this proposal, is phasing in benefits and taxes at different times. But when this 2,074-page bill is fully implemented, it will cost $2.5 trillion.

According to CBO, Federal health care spending will actually go up, not down, as a result of this mammoth effort to rewrite one-sixth of our economy. It cuts Medicare by $465 billion—nearly $6 trillion in cuts to a program that is so important to our seniors. Hospitals, nursing homes, home health, hospice—all of those will be slashed in this $465 billion cut to Medicare. It raises taxes $493 billion. So you have here massive cuts in Medicare and massive tax increases.

Who gets hit? Who gets hit with the tax increases? You do. If you have insurance, you get taxed. If you do not have insurance, you get taxed. If you need a lifesaving medical device, you get taxed. If you need prescription medicines, you get taxed. There is also a new Medicare tax.

What is the bottom line here? After weeks of drafting a bill behind closed doors, the majority has produced a bill that increases premiums, raises taxes, and slashes Medicare by $4 trillion, to create a new government program. This is not what the American people want. I do not believe they think this is reform. This is not the direction to take.

I yield the floor.

RESERVATION OF LEADER TIME

Mr. UDALL of New Mexico. Mr. President, I ask unanimous consent, during the time we control for the next half hour, that we be able to engage in a colloquy with other Senators.

Mr. UDALL of New Mexico. Mr. President, for months we have gathered in this Chamber to talk about why we need a public option as part of health care reform. Almost every week the insurance companies provide another example of why a public option is necessary to ensure all Americans have access to quality, affordable health insurance. Our most recent examples come courtesy of two of America’s largest insurance companies—Humana and CIGNA. Wall Street just completed its third quarter earnings season, and Humana and CIGNA released their reports a couple weeks ago. Let’s just say that both companies did very well last quarter. Humana profits in the third quarter were up 65 percent over the same time last year. CIGNA profits in the third quarter were up 92 percent.

Senator BROWN has focused on the insurance company issue and has seen what is happening to the American people. This is happening at a time when 47 million Americans are without access to affordable health care. I will ask him to speak a little bit about the insurance company issue and what is happening.

Before doing so, the Republican leader was here on the floor, and he was talking about the numbers that were given by CBO. These are number crunchers. They are by nonpartisan folks. These are people who work very hard late at night. They have been
working to get out their numbers on the bill that we will have on the floor in a short while. I can't believe we are now hearing they don't like the CBO numbers. Both sides live by CBO numbers. That is the important thing for people to understand. I yield to Senator BROWN.

Mr. BROWN. Mr. President, we are also joined by Senator Reed of Rhode Island and Senator Merkley. They helped write the bill in the HELP Committee. We know Aetna's CEO last year made $21 million. Of the top 10 insurance companies, the average CEO is paid $11 million per year. We know their profits have gone up 400 percent over the last 7 years. It is not so much that CEOs are paid so much. It is not just their profits and their CEO and top executive salaries, it is the business model that gets them there. When you think about what has happened to insurance companies, especially big insurance company, you hire a bunch of bureaucrats to keep people from buying insurance, to invoke preexisting condition so nobody can get insurance or to put limits on coverage so people can't get insurance. Then they hire bureaucrats on these insurance claims—deny claims—80 percent of claims that are filed when people get sick—they turn their claims in to their insurance company from hospitals, doctors, treatments, they turn them in to the insurance company, and they deny them initially. They are appealed sometimes and then they get reimbursement customers, someone who files a claim. But the fact that they have to fight the insurance companies while they are sick anyway or while they are advocating for their parents or a sister or husband or wife, these huge profits and huge executive salaries are based in denying care on preexisting conditions, on squeezing profits from customers. That is how all the small businesses in Rhode Island, Oregon, New Mexico, and Arkansas, all the businesses that say they can't afford insurance anymore. They may have had huge price spikes because 1 person in a company out of 30 employees gets sick.

I don't care all that much about profits and CEO salaries. I do think it is immoral. But what I care about is that those profits and salaries are based on hurting people who have insurance or keeping people from having insurance. Mr. KAUFMAN. How can a business do this? There is a real reason why they can do it. It is because there is no competition. Other companies can't do that. They can't treat the people who are customers the way the insurance companies do. When you look at the list, you can see why they get away with it. There is no competition. In the top 39 States out of 50, over 53 percent of the market share is with 2 companies. There is no competition right now in health insurance. That is the whole reason why we need the public option. The reason for the public option is it allows us to have competition in these States where there is no competition at the present time. You can have gigantic profits. You can have CEOs making millions of dollars. You can have all these things. You can treat your customers poorly. You can do all these things because you don't have to worry about competition in the business and offering them a good or better deal. That is what the public option does.

Mr. UDALL of New Mexico. I yield to Senator Reed to get him involved in this discussion.

Mr. REED. I thank Senator Udall. Senator Kaufman has made an excellent point. What we have seen over the past several years, actually more than a decade, is increasing costs shifted to small business. Just this year, a 15-percent increase in small business premiums is anticipated, much higher than inflation. That is because there is no real competition. Rhode Island is on that map, where two companies control 82 percent of the market. Those are two insurance forces, which have been illuminated, that drive up this constant increase in cost. One is profits. That is what private companies are organized to achieve. If we were directors of those companies, we would do exactly that. But those profits drive two things: One, shareholder return, profitability of stock, and also compensation for executives. Those two phenomena will not be in place in a public option. We will have a not-for-profit cooperative arrangement. So the response will not be to shareholders or to self-aggrandizement of executives; it will be to delivering service. That is going to be a check.

What I find ironic in this discussion is the bold proponents of free markets who believe the free market can solve all problems. Well, we are going to lose our customers. They are going to keep people from buying insurance, or is that fairly accurate?

Mr. KAUFMAN. One final point. You can tell there is no competition when every year your premiums go up. The only way to be similar is to be an insurance company. That—and I don't mean to hurt anybody's feelings—is the cable company and my TV bill. I know every year, no matter whether the inflation rate or the cost of living is down, I will get a notice in December—"We're going to raise your insurance premiums are going up and my cable costs are going up. The reason is because both these are essentially operating as monopolies.

Mr. UDALL of New Mexico. I don't think the American people realize we have exempted the insurance companies from the antitrust laws. Those are laws you can move in, when there is a lack of competition in the market, when there are too few players in the market, to try to inject additional competition in the market. With the public option, the first thing we are trying to accomplish is to inject competition into the market, to have insurance companies be competing. This public option is going to help drive that cost down in a dramatic way.

Senator Merkley, who has worked on this legislation in his committees, joins us today. I hope he can talk a little bit about this last point.

Mr. MERKLEY. Mr. President, there was a time when our colleagues across the aisle were in favor of competition. Correct me if I am wrong, but in the past, we used to have a highly regulated, noncompetitive airline industry. Was it not our good friends across the aisle who said we need to create competition so consumers have real choice and this will drive the cost of airline tickets down? Am I mixed up on that one? Is this an unfair question?

Mr. UDALL of New Mexico. That is an absolutely accurate rendition.

Mr. MERKLEY. We are in a very similar situation here, where we have a noncompetitive industry, costs going through the roof, and the basic factor at work which is, if we introduce competition in health care, service will improve, costs will come down.

Choice is much more important in this area than just about any other. If you are not satisfied with the cost of your insurance or the service you are receiving, then you should have multiple places to go. That is the underlying point of creating a health care marketplace or exchange, as it is called, so citizens can say: Here are all the plans competing against each other. What are they going to offer? A year later, if you are not happy, you get to switch, which says to every single insurance company, if we don't do this, we are going to lose our customers. That is the marketplace. That is competition. That is what we need in America. It will be helped by having a public option.

Mr. UDALL of New Mexico. Absolutely. No doubt about that.

Mr. MERKLEY. I can tell you a couple stories from Oregon. There was an article in the Bend Bulletin in October about two families. One individual, Dale Evans, went to his doctor because he was experiencing pain in his chest. His doctor recommended he have an MRI to find out what was going on. The request was made three times. The insurance company turned it down three times. Because he didn't have this test, there was no diagnosis made of the cancerous tumor he had. His tumor proceeded to damage the nerves in his spinal cord and left him unable to walk. Then it became too large to be operated on. Mr. Evans died the following year, in 2008. As a result of the choice made by the insurance company, a for-profit insurance company, the test was not conducted and the individual died.
Richard Paulus of Bend, OR, has a similar case being filed right now. He, fortunately, is still alive. He was denied repeated requests for back surgery. His doctor argued for a second opinion. The request was made, turned down again. One thing that you have, you have an insurance company that is making decisions related to healing, not related to profits. The second factor is, one of the best ways to drive that, if Mr. Evans and Mr. Paulus were not satisfied, if they had a choice, they would be much more likely to create accountability with the company they are with right now.

Mr. UDALL of New Mexico. I wish to ask the Senator about those circumstances because he knows more of the details, but when you have insurance companies, these for-profit insurance companies we have been talking about that are making incredible profits, when you have insurance companies that own these claims, which is what you alluded to, what people need to realize is, what they have done is they have created an entire administrative bureaucracy within the insurance industry. It has flowed over into our medical providers, where doctors now tell me what they have to do is have people calling the insurance company to push to reverse these denials. So they have created a whole system which tamps down the ability of people to get care. What we are talking about in the public discourse is, you create a nonprofit. They are not in the business of making a profit. They are going to be in the business of providing health care, of doing the very best they can to provide health care. Why it will make the market competitive is they will not have all this administrative run-around. They will not have this going on.

Is that the Senator’s understanding? They will look at the situation you have right there that you have described and they are going to say: It is clear this gentleman needs an MRI because we need to find out what is going on. So they will do the MRI, and then they will move quickly to the care. To me, that is the difference between what the Senator described, where insurance companies are trying to find a way to not pay out, to meet their bottom line, and to raise profits; whereas, a public option would be doing the opposite, focusing on care, focusing on future needs, focusing on providing what people need in the health care arena.

Mr. MERKLEY. Your point is well taken. The overhead in the private health care industry is now 25 to 30 percent. That is a whole lot of folks sitting around desks operating with paper rather than nurses and nurse practitioners and doctors practicing the craft of medicine, the craft of healing. Whereas, Mr. Paulus look at Medicare, instead of 25 to 30 percent overhead, it is somewhere around 3 percent—much less and, therefore, a lot more dollars going into actually assisting folks in getting well. Again, competition is going to drive that overhead.

Mr. UDALL of New Mexico. I say to Senator MERKLEY, the thing the American people should know about the health care plan Senator Reid was the reason that we have lowered—what we have unveiled here in the Senate—is it has a public option in it. So the public option will be there to provide competition. It will be there to provide the very best care. And it will be there to make sure we keep these insurance companies honest. That is what we are trying to do here: to make sure there is competition in the market, to make sure the insurance companies are honest.

Mr. MERKLEY. Yes. The reason we have lost competition is twofold. One, in many markets, a single company dominates the market. Second, even if you have multiple companies, they are exempt from the antitrust laws and, therefore, they can communicate with each other. They go to negate the reductions or even eliminates real competition. That is why this is so important.

There is one feature of this public option that I think is important to recognize. It represents a huge compromise. If you ask any of the many of us who have been here, our Senators said: We are not sure our folks back home are quite sold on this idea, and we do not want to see it “forced on them.” Quite frankly, I think it would be good to have competition in the country, even if everyone have more choices. But in deference to that Federalist tradition in America, in deference to the laboratory of State experimentation, a provision has been included in Senator Reid’s merged bill that says if a State does not want to participate, it can opt out.

So there is no Senator in this Chamber who should have any concern about saying my folks back home do not want this, and they are going to back away from it. Whatever they do, there will be competitive forces. What we need is to be sure the insurance companies are honest. It is really important.

Is that the Senator’s understanding? I have been here on the floor with Senator MERKLEY—I know Senator Reid was just here—participating in a colloquy. The point that both of them, I think, make is when you inject a public option into the insurance market—having to pass a law, the Governor having to sign it, and say: We do not want to have anything to do with the public option. But we realize with a public option you bring competition to the market, you expose these high administrative costs, you talked about. One of the things people do not realize, on administrative costs, is, the Federal Government runs the Medicare Program. Here you have a program that when I go to town hall meetings, I say: Raise your hand if you are on Medicare. They will put their hand up. And I will say: Keep your hand up if you like Medicare. So they will raise their hand, and they will keep it up.

Ninety-five percent of the people like Medicare. Well, Medicare has a 3 percent—3 percent—administrative cost. As the Senator said earlier, the insurance companies we are dealing with have anywhere from 25 to 30 percent administrative costs. So if you put a public option in there, you are going to have competition. Senator MERKLEY.

Mr. MERKLEY. I say to the Senator, let me give you an example of how that competition can work in a health insurance marketplace. In Oregon, we have a public option in workers compensation, which is health insurance for injuries that occur on the job. We have had this public option for 80 years. It did not work that well. It was not well-designed, and it was not well managed.

About 20 years ago, a group of businesses got together, and the businesses said: We need a better insurance policy. We need a better competitive market for on-the-job health insurance. So in a deal that was called the Mahonia Hall deal, Mahonia Hall rewrote and improved the management of our public option. The result is, rates today in workers compensation in Oregon are half of what they were 20 years ago, because competition was introduced, efficiencies occurred, service improved. I can tell you, there is not a business in Oregon to be found campaigning to eliminate the State accident insurance fund, which is a public option in work-based health care.

Our colleague SHELDON WHITEHOUSE was involved in establishing a very similar program in Rhode Island. Their workers comp, he told me—and I think he has told this Chamber—introduced by Rhode Island adding a work-based health care public option resulted in their rates dropping by half.

Wouldn’t it be great if competition could reduce health care costs in America rather than having 10 to 15 percent increase every single year?

Mr. UDALL of New Mexico. Yes. I say to the Senator, you hit it on the head. I have been here on the floor with Senator WHITEHOUSE—I know Senator Reid was just here—participating in a colloquy.
whether it is health insurance, whether it is workers’ compensation—you inject competition. And by injecting that competition, you make the marketplace work a lot better. That is what we are striving for here today.

Senator MERKLEY. Mr. MERKLEY. There are folks who have said: Well, now, hold on. Isn’t this a government takeover of health care? Since that has been said so many times on this floor by those who oppose health care reform, I think we should address it directly. Introducing a competitor does not have the government taking over health care. It is an option citizens can choose—if they are not satisfied with the current performance—competing on a level playing field. This is exactly what you need when you have markets that have lost their competition.

It is important to note this phrase “government takeover” came out of a study contracted for by my colleagues across the aisle to say: How can we defeat health care? They polled folks in America and said: What are the scariest terms we can use—even though we do not know what the plan is; even though we do not know whether the health care system needs reform; we do not know if the plan is going to invest in disease management; we do not know if the plan is going to have healthy choice incentives that will help improve the quality of life of Americans and decrease health care costs; we do not know if we will have insurance reforms that will get rid of dumping, the practice of throwing people off their health care plan once they get sick; we do not know whether there will be reforms that say there will be guaranteed issue, you cannot be denied the opportunity to have health care because of preexisting conditions. We do not know any of that, but whatever it is, we are going to be against it. So let’s con the. And they tract to do the studies. Let’s find out how to scare Americans. The result was: Let’s call it a government takeover.

I have to tell you, this is too important an issue to the citizens of our Nation. Health care touches every individual, touches every small business, trying to succeed. It touches every large business trying to compete around the world, with much more efficiency—much more efficient health care to other countries. It is too important than to do studies to try to find words to scare Americans.

How about we try to solve problems in this Chamber? I am going to tell you, I think this bill put forward last night by Majority Leader Reid is not solving a problem absolutely critical to our economy, critical to our small businesses, critical to the quality of life of our families.

Mr. UDALL of New Mexico. I say to Senator MERKLEY, you are exactly right. Senator Reid has put a merged proposal on the floor, and do you know what the response is we have seen? I like your comments on this. The response we have seen I find amazing, because here is what we are facing.

The American people want health care reform, so we have announced we would file the bill to the floor to reform health care. We have been working on it for months. It is out of two committees. We have brought it together. So what do we have to do in the Senate to move forward? We file a motion for cloture. Let’s get the math right to proceed. You are not even on the bill.

Do you know what is going to happen? The Republicans are going to step forward, their leadership is going to step forward, and they are going to say: No, no, we are not going to agree to that. We are not going to agree to even proceed to the bill. So we are going to have to file cloture. When we file a cloture motion it is going to take 30 days before that cloture motion ripens. Then we are going to have a cloture vote. Then 30 more hours are going to expire. They are going to require us to use all that time. Even though we may be in a room full of people talking, calling an cloture, they are going to require that. Then, believe it or not, they are going to require us—these wonderful clerks who work up here—they are going to require them to stand up for 50 hours and read that bill on the floor—50 hours. The normal thing we do to get to something is we waive the reading. But they are going to require it.

What does the Senator think of that approach? I do not think the Senator will say...

Mr. MERKLEY. Many Americans are familiar with the tradition of a filibuster, and they envision it where Senators stand up and speak and speak on an issue of principle. That was used very rarely. It is the thing to do. It was used very rarely. It is the thing to use. However, the normal thing we do to get to something is we waive the reading. But they are going to require it.

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This 60-vote test is most often used at the end of a debate. Do we go to a final vote? Are we going to wrap up debate and go to a final vote? But in this case, as the Senator has described it, it is going to be used even to hold a debate on health care in this Chamber. All my life—I first came to this Chamber when I was an intern for Senator Hatfield in 1976—all my life, I have heard the Senate described as “the world’s greatest deliberative body.” Well, that is a pretty cool thing. But are we going to require that? Are we going to try to block this Chamber from even debating health care?

Mr. UDALL of New Mexico. That is exactly what I am saying. We have worked hard. The majority has worked hard. We have had hearings—Democrats and Republicans—in those committees. When we file a motion to proceed, we are not even on the bill, we cannot amend the bill. When we file that motion to proceed, they are going to require we take 2 full days, and then another 30 hours, and then demand we read the bill on the Senate floor. I see Senator ALEXANDER in the Chamber. I know there are good friends of ours on the other side who do not want to see that kind of thing proceed. But a couple of Senators can muck up the whole works here and slow this thing down.

I think the American people want us to move forward with health care. I think they want us to get something done that provides health care for people, that provides choices, that keeps people’s doctors, that puts competition in the market—all of those kinds of things.

Senator MERKLEY.

Mr. MERKLEY. Mr. MERKLEY. I join the Senator in saying to all my colleagues, do not fear debate on health care. We are here, and it is our job to come and debate. It is our job to come and talk about how important it is to have insurance reforms so people are not barred because of preexisting conditions, people are not dumped after a decade of being provided insurance because they get sick.

It is so important we have this debate, and I look forward to having it, and hope all colleagues will join in saying: Yes, no matter which side of this issue you are on, it is time to debate, and citizens have a right to do that.

Mr. UDALL of New Mexico. I say to Senator MERKLEY, thank you. Thank you for joining me in this colloquy today.

I thank the Acting President pro tempore and yield back any time at this point.

The ACTING PRESIDENT pro tempore. The Senator from Tennessee.

Mr. ALEXANDER. Mr. President, I wonder if you could let me know when I have consumed 9 minutes.

The ACTING PRESIDENT pro tempore. The Senator will be so notified.

Mr. ALEXANDER. Thank you, Mr. President.

HEALTH CARE REFORM

Mr. ALEXANDER. Mr. President, I was listening to my friends on the Democratic side. I wish they could have been in the Senate 4 or 5 years ago. Actually that would have reduced our numbers, so as much as I like them, I would not have wished that. If they had been here, they might have been some help in arguing to the Democrats who blocked Miguel Estrada from becoming a judge, and Senator McConnell, who blocked Judge Pryor of Alabama from having an up-or-down vote. The Democrats at that time seemed to argue a completely different point of view.

What we want on the Republican side is very simple.

You see this bill I am leaning against? This is the new bill. This is the Harry Reid—the distinguished majority leader’s health bill. We want to make sure the American people have a chance to read it and they have a chance to know exactly what it costs and they have a chance to know exactly how it affects them. That is not
an unreasonable request, we don’t think. That is the way the Senate works. That is our job.

When it came to the Defense authorization bill, we spent a couple of weeks doing that. When it came to No Child Left Behind, we spent 7 weeks going through it, and neither of those bills was 2,074 pages long. The Homeland Security bill took 7 weeks. The Energy bill in 2002 took 8 weeks. A farm bill last year took 4 weeks. So, if we do a little reading and a little work to do, we have done some preliminary reading, but what we want to make sure of is that the American people read the bill, know what it costs, and know how it affects them because health care is a very personal matter.

I have done some reading since the bill came out last night. I was also a little bit amused to hear our friends complain in terms of the Thanksgiving things down well. This bill has been hidden in the majority leader’s office for 6 weeks. He wouldn’t let any of us read it. I don’t know who he has been in there with writing it, but I guess it takes 4 weeks to write a 2,074-page bill. But he didn’t bring it out until last night, and now we have it printed out. Now he wants to vote on Saturday. Well, that is all right with us if he wants to vote on Saturday or Sunday or Monday, or Thanksgiving Day. We are going to be here because these are the most important set of votes we are ever likely to take in this body, at least during the time I am here.

Let me give a preliminary report to the American people in terms of the Thanksgiving spirit about this bill. It came out with a lot of fanfare. It has been hidden in the majority leader’s office for 6 weeks, but here is my early warning: this bill took 4 weeks. We are going to be here because these are the most important set of votes we are ever likely to take in this body, at least during the time I am here.

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Please know that I do support some health care reform; however, I cannot in good conscience support any legislation that contains any abortion mandates.

Someone from Bellevue, NE, said, and I am quoting again: I am writing to urge you to ensure that language is included in any health care reform proposal or bill to explicitly exclude abortion. The use of my tax dollars forces me to support a procedure that is against my conscience.

So as we move forward, we need to focus on what people are saying to us. That is why in this bill we need the exact language in the House bill.

The Stupak amendment is the essence of a continuation of current law. Don't be fooled by those who suggest this is something new and different. The Hyde law prohibits Federal funding of abortion through Federal programs such as Medicaid. It prohibits Federal funding for private health insurance policies that cover abortion. An example is the current Federal Employees Health Benefits Program. The 250 participating health plans do not cover elective abortions. Federal employees pay a share of the cost. The Federal pays half; the employees pay the other half—or the taxpayers. Federal employees cannot opt for elective abortion coverage because taxpayer dollars are subsidizing the cost of the employee plans.

As I said, we have debated this bill, if it is good enough for Federal employees, well, it should be good enough for the citizens.

The Stupak-Ellsworth-Pitts amendment says: New government subsidies could not be used to purchase an insurance plan that covers abortion. The proposed government insurance plan also could not cover abortion. However, the stark and alarming differences that exist in the Senate bill are immediately obvious.

The Senate bill says: People who receive a new government subsidy could—could—enroll in an insurance plan that covers abortion. It requires—at least one plan on the insurance exchange to offer abortion services.

Supporters say: Don't worry. Public funds would be segregated, so they wouldn't be used for abortion. But this provides no solace whatsoever: It is impossible to segregate funds. How will the government taxpayer citizens who receive a subsidy to buy a health insurance plan not use those Federal dollars to pay for health insurance premiums?

Put another way: citizens get charged a premium that includes abortion coverage. The taxpayers pay a percent of the premium. Who can determine what dollar went here or what dollar went there? Well, as many have pointed out already, it is a shell game. Nothing more, nothing less.

The Senate's a sharp detour from current law. The very clear line established by the Hyde amendment is obliterated. The Federal Employees Health Benefits Plan does not allow this shell game and neither should this new regime.

National Right to Life is not fooled by this game. They call this provision "completely unacceptable." It was recently included in the language and saw through it. National Right to Life goes on to say that it "closely mirrors the original House language that was rejected by 64 Democrats." I am going to quote:

It tries to conceal that unpopular reality with layers of regulations and loopholes, and low-bookkeeping requirements.

I stand here today to say to National Right to Life, thank you for standing up for life. I hope more will do the same. You are absolutely correct in saying that it would "require coverage of any and all abortions throughout the public option program. This would be Federal Government funding of abortion, no matter how hard they try to disguise it." They weren't fooled.

My best word for this is that other pro-life leaders will courageously stand up today and tell Americans they should not be fooled either. We have to draw a line. This isn't a partisan issue.

The leadership, the Democratic leadership, has said: New government subsidies. It is our last chance to protect life in this debate.

Congressman STUPAK and about 40 of his Democratic colleagues stood strong on their pro-life convictions, and they literally changed the outcome in the House. They stood in the Speaker's office and said about this procedural vote: Look, if it is not pro-life, we are not there. And the Speaker had no choice but to put the Stupak amendment up for a vote. Over 40 courageous Congressmen stuck to their convictions, and they made a difference.

Today in the Senate, we don't need 40 Democrats to stand up for what is right; we need just 1. If just one pro-life Democrat would say: I will not vote to move this bill until it is fixed, until it is truly pro-life, that would do it.

Those who say they are pro-life but refuse to take that stand, I worry they are not standing up for life.

I have a record of voting pro-life. I know how I am going to vote on this. Because it is this simple: I will ask for a pro-life Senator to come down here and stand up on this bill. Pro-life Americans are waiting, and they are not fooled.

I yield the floor.

The PRESIDING OFFICER (Mr. BENVENET). The Senator from Wyoming is recognized.

MR. BARRASSO. Mr. President, here you have it, what we have been waiting for. We have weeks and weeks, what has been put together behind closed doors. People all across the country have seen the doors behind which people, in secret, have been writing this bill. It is 2,074 pages. Some people call it remarkable; I call it a monstrosity. And the majority, Senator REID, has said that of all the bills we have seen, it will be the best. Mr. President, it is the best of the worst. It just looks more of the same. All of the things I have been talking about—it still does those sorts of things. It still raises taxes on Americans, higher payroll taxes—and this is the Associated Press talking, not just me. Companies will pay a fee. That is from the Associated Press as well. It adds an array of tax increases, a rise in payroll taxes. That is from the Washington Post. It relies primarily on a new tax. That comes from the Washington Post as well. Then the New York Times says: New taxes and new fees. It is more of the same. It is the best of the worst.

What about Medicare cuts? Oh, they are in here, too, you better believe it. It is relying on cuts in future Medicare spending to cover costs. That is from the Associated Press. It is financed through billions of dollars in Medicare cuts. That is from the Washington Post. There will be reductions in Medicare. It is all in here—taking away the
health care of the seniors of this country. who have relied on Medicare and have been promised Medicare, to start a brandnew program which is in these 2,074 pages. It is just wrong.

Then look at the budget gimmicks. The legislation—after the CBO came up with some number, but it is not what the real cost is. This thing is going to cost $2.5 trillion over a 10-year period. They try to get the number down. How do they do it? They start collecting taxes on day one, but until they implement the program—the things that are supposed to help Americans, they have delayed those things through 2014. Here we are in 2009, and the people who are watching at home and saying: This is going to help me next week, forget it, wait another 5 years. That is the way they maneuver and manipulate the numbers.

Here we have it—a bill that still raises taxes, still cuts Medicare, uses lots of the gimmicks, and will cost the American people trillions and trillions of dollars.

Mr. President, obviously health care is one of the most important issues Congress is going to take up this year and one of the most important issues in the Senate. This may be the most important issue and bill we are ever asked to vote upon.

I travel home to Wyoming every weekend. I talk to people. I was there for 5 days over Veterans Day. I say to them: What do you need? What do you think? What are your thoughts on this?

They say: Deliver to Washington a clear and simple message: Fix what is wrong with the health care system. Whatever you do, don’t make things worse for me.

I have town meetings and ask people: Do you think it is going to cost more and get less, or better or worse? People believe it is going to cost them more for my family's health care. But that is what is going to happen across the board. Premiums are going to increase, the premiums for people who have insurance—the premiums people pay who have insurance. For the 85 percent of Americans who have insurance, those costs will go up. This plan was announced a year ago, to get costs down, to get premium costs down. This raises the premiums for the American people.

Some people are living in a time and in an economy when people say they can't afford this sort of a bill. The American people don’t want it.

I travel around the State and visit with people. I visited with a young lady from Cody, WY, who has health insurance through her job, and she likes it. She takes care of her family. She found out that because of increasing premiums—which will get worse if this bill passes—the people think they are going to get will not be comprehensive. In some cases they had their pay cut a little bit so they can continue with the health care they have. They like the care, but they don’t like the cost of their care. Again, this doesn’t get the costs down for American families. Premiums will go up.

This is what we have been seeing all across the country. Whether it is independent people, whether it is people who work for government, whether it is employees, whether it is someone who buy insurance or people who need insurance, across the board, people say these atrocious health care proposals will make matters worse for the families, for the men and women of this country. They are going to be paid for not just by them but also by the young people, as the debt continues to accumulate in our Nation and goes on to impact the young people of this Nation.

The people of Wyoming want practical, commonsense health care reform—the kinds of reforms that will drive down the cost of medical care, that will improve access to providers, that will create more choices. They don’t want things that will increase the costs or things that will limit access or things that will take away their choices.

Obviously, the majority leader and the Democrats in Congress have a very different plan. Their legislation is going to force upon Americans higher health insurance costs through higher premiums, higher taxes, Medicare cuts, and more government control over health care decisions. That is not reform.

There are only two physicians in the Senate. The two of us bring a unique perspective to the health care debate. I practice medicine, taking care of families from all across the great State of Wyoming. I have dedicated my life’s work to helping patients live longer, live healthier, and stay well. I can say, without reservation, in this Nation, we do offer some of the finest medical care
in the world. I am not blind to the fact that our health care system has failings. I have seen them firsthand. We can fix a broken system in a way that actually works to get costs down, to get more people covered, to give people more choices, and it is in this atrocious plan, which raises taxes, cuts Medicare, and takes away choices from the American people.

CONCLUSION OF MORNING BUSINESS

The PRESIDING OFFICER. Morning business is closed.

CAREGIVERS AND VETERANS OMNIBUS HEALTH SERVICES ACT OF 2009

The PRESIDING OFFICER. Under the previous order, the Senate will proceed to the consideration of S. 1963, which the clerk will report.

The assistant bill clerk read as follows:

A bill (S. 1963) to amend title 38, United States Code to provide assistance to caregivers of veterans, to improve the provision of health care to veterans, and for other purposes:

The PRESIDING OFFICER. The Senate from Oklahoma.

AMENDMENT NO. 2785

Mr. COBURN. Mr. President, I call up amendment No. 2785.

The assistant bill clerk read as follows:

The Senate from Oklahoma [Mr. COBURN] proposes an amendment numbered 2785.

Mr. COBURN. Mr. President, I ask unanimous consent that I be permitted to use my time on the bill and my time on the amendment as necessary.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. AKAKA. Mr. President, as chairman of the Senate Committee on Veterans' Affairs, I have the honor of speaking at the World War II Memorial this past Veterans Day. As I stood there remembering my own comrades and their families, I thought of what the brave men in the service give up every day so we can enjoy the freedoms that come with American citizenship.

It is in that spirit that I urge this body to pass S. 1963, the Caregivers and Veterans Omnibus Health Services Act of 2009 without further delay.

The Nation's young veterans coming home from Iraq and Afghanistan have faced a new and terrifying kind of warfare, characterized by improvised explosive devices, sniper fire and counterinsurgencies. Military medicine, fortunately, is saving more of these young servicemembers' lives than ever before.

In World War II, 30 percent of Americans injured died. In Vietnam, 24 percent died. In the wars in Iraq and Afghanistan, about 10 percent of those injured have died.

As more of the catastrophically disabled are surviving to return home, more will require a lifetime of care. With our decision on S. 1963, we decide whether that care will be in their homes with the help of their family members or in institutions. If we want that care to be in the home, we need to help the families shoulder the burden of providing it.

During the prior administration, the President's Commission on Care for America's Returning Wounded Warriors—known as the Dole-Shalala Commission—found that 21 percent of Active Duty, 15 percent of Reserves, and 21 percent of retired or separated servicemembers who served in the Iraq or Afghanistan conflicts said friends or family members gave up a job to be with them or to act as their caregiver. By giving up a job, caregivers often gave up health insurance, when they need it the most.

Studies also show family caregivers experience an increased likelihood of stress, depression, and mortality, compared to their noncaregiving peers.

Without a job, without health insurance, and in very stressful situations, family caregivers have worked to fulfill the Nation's obligation to care for its disabled warriors.

S. 1963 would give these caregivers health care, counseling, support, and a living stipend. The bill would provide caregivers with a stipend equal to what a home health agency would pay an employee to provide care. It would give the caregivers health care and make mental health services available to them. The bill also provides for respite care so caregivers can return to care for these veterans with renewed vigor and energy. It lets these young veterans return to their families and not to a nursing home.

While the caregiver program in this legislation will be limited at first to the veterans of the Iraq and Afghanistan wars, other provisions of the bill improve health care for all veterans.

There are provisions which make health care quality a priority, strengthen the credentialing and privileging requirements of VA health care providers, and require the VA to better oversee the quality of care provided in individual VA hospitals and clinics.

The bill will also improve care for homeless veterans, women veterans, veterans who live in rural areas, and veterans who suffer from mental illness.

About 131,000 veterans are homeless. S. 1963 would help these veterans obtain housing, pension benefits, and other supportive services. It would provide financial assistance to organizations that help homeless veterans.

Seventeen percent of servicemembers are now women. This legislation contains a number of provisions which are designed to improve the care and services provided to women veterans.

It would provide for the training of mental health professionals in the treatment of military sexual trauma and provide care for the newborn children of servicemembers. It would give women veterans a quality of care they have earned through their service to this country.

The bill also provides new assistance to veterans who live in rural areas. According to the VA, of the 8 million veterans enrolled in VA health care, about 3 million live in rural areas. This legislation would bring more services into rural communities through telemedicine and increased recruitment and retention incentives for health care providers. It would also increase the VA's ability to use volunteers at vet centers and create centers of excellence for rural health.

Finally, S. 1963 addresses the signature injuries of this war—PTSD and traumatic brain injury. According to a recent RAND report, one in three veterans returning from Iraq and Afghanistan will develop post-traumatic stress disorder. Countless others will suffer from traumatic brain injury and face
significant problems in readjusting to life at home. Many studies have shown the importance of early intervention to the effective treatment of these invisible wounds.

This legislation contains provisions that allow Active-Duty military to seek mental health services at VA centers and increase access to care for veterans with traumatic brain injury.

Before concluding, I wish to share one of the many stories I have heard as I have worked to move this legislation through the Senate.

SGT Ted Wade sustained a severe brain injury after his humvee was hit by an improvised explosive device in Iraq. His right arm was completely severed above the elbow, and he also suffered a fractured leg, broken right foot, and visual impairment, among other injuries.

His wife Sarah Wade became his caregiver and a dedicated advocate for her husband and for others who are providing caregiver services.

In testimony before the House Veterans’ Affairs Committee earlier this year, Ms. Wade made the point that:

Young veterans with catastrophic injuries need long-term care and support for as long as the injuries they sustained in service to their country. Just like service members need a team in the military to accomplish the mission, they need a team at home for the longer war.

I agree completely with that view. Veterans need all the support we can provide. We, as a country, can give them options that veterans of my generation would not have had. We can give them the options to really come home.

To those who are concerned about the cost of this legislation, I say we cannot turn our back on the obligation to care for those who fought in the current wars. When we as a body vote to send American troops to war, we have promised to care for them when they return.

I firmly believe the cost of veterans benefits and services is a true cost of war and must be treated as such.

I ask that our colleagues accept no more delays and act on this important legislation.

Mr. President, I reserve the remainder of my time and yield the floor.

The PRESIDING OFFICER. The Senator from North Carolina.

Mr. BURR. Mr. President, I thank and congratulate the chairman of the VA Committee. This is important legislation for this body. It is my belief that this will move very quickly, as we can see from the short time agreement: one amendment—one amendment that I think is extremely important for all Members of the Senate to consider.

I rise in support of S. 1663, the Caregivers and Veterans Omnibus Health Services Act of 2009. This is actually the combination of two bills reported out of the Veterans’ Affairs Committee this year and it did enjoy bipartisan support.

The centerpiece of the legislation is the support it would provide to caregivers of severely injured veterans of current wars. The bill would provide counseling, support, living stipends, and health care for those caregivers.

As my colleagues know, family caregivers play an extremely important and, I might say, unique role in helping to meet the severely injured veterans’ personal care needs. For some veterans, family members serve as their primary caregiver; some of whom have lost their jobs but, more importantly, have lost their health care as a result of that commitment to that family member.

As the chairman spoke about a servicemember he had remembered in this—Ted Wade is a North Carolinian—he made the same impression with me. I also think about caregivers Edgar and Beth Edmundson from North Carolina as well, the parents of Eric Edmundson, a severely injured veteran from Operation Iraqi Freedom. They have been caring for Eric since the day he was hit by an improvised explosive device in Iraq. His right arm was completely severed above the elbow, and he couldn’t talk. He couldn’t walk and he couldn’t talk.

After Eric was injured on patrol along the Iraqi/Syrian border, he went into cardiac arrest while he was awaiting transport to Germany. It was in fact that cardiac arrest, that traumatic brain injury, that put Eric in a situation where he couldn’t walk and he couldn’t talk. Under his father’s constant attention and relentless pursuit of new options, Eric received the treatment he needed. Without his dad’s commitment, without the commitment of the rest of Eric’s family—who basically dropped everything else important in life to focus on his needs—Eric would not be in the vegetative state.

Under his father’s constant attention and relentless pursuit of new options, Eric received the treatment he needed. Without his dad’s commitment, without the commitment of the rest of Eric’s family—who basically dropped everything else important in life to focus on his needs—Eric would not be doing as well as he is today. I might say he walks and he talks and he can now carry on a conversation. He lays in that VA long-term care provided by the Veterans Administration, he got no better. He couldn’t walk and he couldn’t talk.

Eric’s father stepped to the plate and immediately began researching all the options for Eric’s treatment. Despite being told his son would not emerge from his vegetative state, Ed Edmundson pushed on. He sold his business, he cashed in his savings and retirement pay, all in an effort to provide Eric 24-hour care as a father.

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Health Care Act. Let’s make sure we pay for it with the Coburn amendment, and let’s pull that money out of already appropriated funds so we can not only look at our veterans, but we can look at our children and tell them this is a good bill.

I yield the floor.

The PRESIDING OFFICER. The Senator from Hawaii.

Mr. AKAKA. Mr. President, I yield 10 minutes to the Senator from Washington, Mrs. Murray.

The PRESIDING OFFICER. The Senator from Washington is recognized.

Mrs. MURRAY. Mr. President, last week many of us spent time back home celebrating our veterans and honoring the great sacrifices they made for our country. I had the opportunity to commemorate Veterans Day at the Tahoma National Cemetery in Kent, WA. It was truly an honor to stand with veterans and their families as we paid our respects to those who have served.

This recognition is important, it is certainly deserved, but it is not enough. We owe it to our veterans to make sure our commitment to them extends beyond Veterans Day and that they have access to the health care and services they need.

Growing up, I saw firsthand the many ways that military service can affect both veterans and their families. My father served in World War II. He was one of the first soldiers to land in Okinawa as a disabled veteran, and he was awarded the Purple Heart.

Like many soldiers of his generation, my dad did not talk about his experiences to us when he came home. In fact, we only learned about them by reading his journals after he passed away. That experience offered me a much larger lesson about veterans in general.

They are reluctant to call attention to their service. They are reluctant to ask for help. That is why we have to publicly recognize their sacrifices and contributions. It is up to us to make sure they get the recognition they have earned. Our veterans held up their end of the deal, now we have to hold up ours.

As a member of the Veterans’ Affairs Committee, I am keenly aware that we have a lot of work to do for the men and women who served us. Not only must we continually strive to keep up our commitments to veterans from all wars, but we have to also respond to the new and very different issues facing veterans who are returning from Iraq and Afghanistan today, wars that are being fought under conditions that are very different from the ones in the past. That is precisely what the caregivers and veterans omnibus health bill that is before us today aims to do.

One of the changes we have seen in our veterans population recently is the growing number of women veterans who are seeking care at the VA. Today more women are serving in the military than ever before, and over the next 5 years, in fact, the number of women seeking care at the VA is expected to double. Not only are women answering the call to serve at unprecedented levels, they are also serving in a very different capacity.

In Iraq and Afghanistan, we have seen wars that do not have traditional front lines; therefore, all of our servicemembers, including women, find themselves on the front lines. So whether it be at the check points or helping to search and clear neighborhoods or supporting supply convoys, women servicemembers face many of the same risks from IEDs and ambushes as their male counterparts.

But while the nature of their service has changed, the VA has been very slow to change the nature of the care they provide for these women when they return home. Today at the VA there is an insufficient number of doctors and staff with specific training and experience in women’s health issues, and even the VA’s own special studies have shown that women veterans are underserved. That is why included in this veterans health bill that I was lucky enough to introduce today is a bill I introduced that will enable the VA to better understand and ultimately treat the unique needs of our female veterans. That bill authorizes several new programs and studies, including a comprehensive look at the barriers women currently face in accessing care through the VA. It is a study of women who have served in Iraq and Afghanistan to assess how those conflicts have affected their health.

There is a requirement that the VA implement a program to train and educate and certify VA mental health professionals to care for women with sexual trauma, and there is a pilot program that provides childcare to women veterans who are seeking mental health services at the VA.

This bill is the result of many discussions with women veterans on the unique and very personal problems they face when they return from war. Oftentimes after veterans meetings I held in which male veterans would speak freely about where they believed the VA wasn’t meeting their needs, women veterans would approach me afterwards and ask up to me very quietly and whisper about the challenges they face.

Some of these women told me they don’t view themselves as a veteran even though they are now that they don’t seek care at the VA. Others told me how they believed the lack of privacy at their local VA was very intimidating, or about being forced into a caregiving role that prevented them from seeking care. They would often have to struggle to find a babysitter just in order to keep an appointment. To me and to the bipartisan group of Senators who have cosponsored my women veterans bill, these barriers to care for women veterans were unacceptable.

As more women now begin to transition back home and step back into careers and their lives as moms and wives, the VA has to be there for them. This bill we are talking about today will help the VA modernize to meet their needs.

Another way this bill meets the changing needs of our veterans is in the area of assisting caregivers in the home. As we have all seen in Iraq and Afghanistan, medical advances have helped save the lives of servicemembers who, as we know, in previous conflicts would have lost the severity of their wounds. But these modern miracles also mean many of those who have been cast catastrophically wounded need round-the-clock care when they come home. In many of our rural areas, where access to health care services is limited, the burden of providing care often falls on the families of those severely injured veterans.

For these family members, providing care for their loved ones becomes a full-time job. Oftentimes we hear they have quit their jobs, or they have had to struggle, often sacrificing not only their source of income but often their own health care insurance as well. That is a sacrifice that is far too great, especially for families who have already sacrificed so much. That is why this bill also provides those caregivers with health care, with counseling, with support, and, importantly, a stipend.

This bill also takes steps to provide dental insurance to our veterans and spouses and their families.

It improves mental health care services and eases the transition from active duty to civilian life. It expands outreach and technology to provide better care to veterans who live in rural areas. It initiates three programs to address homelessness among veterans at these especially difficult economic times.

This is a bill that is supported by numerous veterans service organizations, both men and women, and it is supported by many leading medical groups. It was passed in the Senate Veterans’ Affairs Committee with broad bipartisan support, after hearings with health care experts and VA officials and veterans and their families. Like other omnibus veterans health care bills before us, bills that have often passed on the floor with overwhelming support, it puts veterans before politics. It is a bipartisan bill designed to move swiftly so its provisions can be implemented right away. It is a bipartisan bill designed to make sure our veterans do not become political pawns. Yet we have faced a lot of delays in getting here. Those delays are all too common here in the Senate.

We have seen bipartisan nominations stalled, funding bills slowed down to a crawl. It has taken us months to pass a simple extension of unemployment benefits for people who are out of work. Providing for our veterans used to be one area where political affiliation and bipartisanship bickering fell to the wayside. I hope those days are not behind us. Our aging veterans and the brave men and women who serve in Iraq and
Afghanistan need our help now. How we treat them at this critical time is going to send a signal to a generation of young people who today might be considering military service.

As I have said many times, it is so important that we keep our promise that Abraham Lincoln made to America’s veterans 140 years ago, “to care for the veteran who has borne in battle, his widow and his orphan.”

Our veterans have waited long enough for many of the improvements in this bill. We cannot ask them to wait any longer.

I spoke last week on the floor on the eve of Veterans Day urging colleagues to move quickly on this bill. I am so glad progress is now being made toward making that happen. As we wait to pass this bill, our promise goes unfulfilled to many of our Nation’s heroes. I urge my colleagues to pass this bill quickly so we can get to the work of providing our veterans with support and services they have earned.

I thank the Chair.

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. MURRAY. Mr. President, the reason we are having the debate now is because nobody would have the debate earlier. It is important for the American people. I don’t have any opposition to veterans care. As a matter of fact, I support keeping our commitment. But there is something wound out, on October 28 it came to the floor. Part of my amendment, when it actually came out of committee, was in the bill. It was taken out before it came to the floor, not by the members of the committee. It was taken out. But the very fact that we make an issue, because somebody wants to debate a bill and offer amendments on a bill, and then we are supposedly antiveteran because we think maybe we ought to pay for some things we do around here, so because we want to pay for it, we are cast aspersions that we don’t want it to be debated. The worst thing that happens in this body is we pass bills that the American people have no idea about because we refuse to debate them.

I apologize to no one for having put a hold on this bill for a very good reason. The very good reason is this: Our veterans demonstrate courage greater than we ever demonstrate in this body. We owe it to them that we make their needs a priority. What is the courage I am talking about? The courage to make priorities, to make sure we keep those commitments. This bill, as it is written now, will cost $3.7 billion over the next 5 years. I think we ought to do that for these veterans. But I also think their sacrifice should not be in vain and stolen and paid for by their grandchildren. I believe we ought to pay for what we are going to do.

It is regarding that the Senator from Hawaii mentioned speaking at the World War II memorial. This bill, as written, excludes World War II veterans from the benefit. It excludes Gulf war veterans from the benefit. What about them? Is the reason the other veterans, the Vietnam war veterans, the Korean war veterans were not included is because we thought we couldn’t afford it? I think that is probably the reason. Which begs the question, what about our veterans? When we have promised our veterans, we ought to treat them the same, one, and we ought to have the courage to make hard choices about how we pay for it.

It is easier to charge this money to our grandchildren. I have no doubt that is what we will end up doing. But the biggest threat facing our country today is not Islamic fascism and Islamic terrorism. The biggest threat facing the country today is the fact that every young child born today will encounter $400,000 worth of debt for benefits they will get nothing from. When we calculate the interest cost on that, by the time they are 25, they will have been carrying a debt load of $1,119,000.

As I look at my colleagues who want to do this but don’t want to pay for it, I am bewildered to think that we can call and honor the courage and service of our veterans without taking some of the same courage to make some hard choices about things that are not nearly as important as our veterans. We can’t do both. We can’t continue down the road we are on. We can’t continue to spend the money we are spending and borrowing, 43 cents of every dollar we spent this last year, borrowing it from our grandchildren. It won’t work. We will fail as a nation.

Look at President Obama’s recent trip to China. What was the message that emerged? They are worried about us financially. They are worried about our deficit spending. Why are they worried? Because they own close to $1 trillion worth of our debt. They now impact our foreign policy decisions only by the fact that they own so much of our debt.

Can we continue to do this and have a free America? Can we continue to do this and our children have opportunity, at least to the level we have experienced? What are our veterans fighting for? Why did they put their bodies at risk, if it is not for a greater future for the country?

When we think about this past year—and it will be worse next year. It will be 44, 45 cents borrowed of every dollar we spend this year. This bill will put on our grandchildren as well as our veterans. This isn’t even a hard vote. Our entire contribution to the United Nations is wasted in the fraud of the peacekeeping we contribute to. We contribute 25 percent of the United Nations money, and we have reports and studies and leaked documents that show the vast majority of the money we put in the United Nations gets defrauded from the United Nations. We are going to get a choice with this bill. We will say we will treat all veterans the same, No. 1, and we are actually going to pay for it by saying it is a greater priority to take care of our veterans than to fund a corrupt, fraudulent peacekeeping force as run through the United Nations. That is what we are going to say.

If this amendment passes, it will send a wonderful signal to the United Nations to clean up their act. It will send a message to our children and grandchildren that we will finally start acting responsibly, and it will send a great message to veterans that we do care and we care enough to make sure the sacrifice they made will not be undermined by us not making hard choices.

We owe a lot to our veterans. The No. 1 thing we owe them is to make sure what they fought for and the future we have is secure in our children and grandchildren’s generation. It is not secure today, based on the fiscal situation we find ourselves in.

I reserve the remainder of my time.

The PRESIDING OFFICER (Mrs. Murray). The Senator from Hawaii.

Mr. BEGICH. Madam President, I rise in support of S. 1963, the Caregivers and Veterans Omnibus Health Services Act of 2009. I am pleased we are now considering this bill. S. 1963 is comprehensive legislation that addresses many of the needs of our veterans and their caregivers. The bill is a compilation of two earlier bills introduced by Chairman AKAKA to improve veterans health care and provide much needed benefits to their caregivers. I thank the chairman of the Veterans’ Affairs Committee for his leadership on this bill and in committee. He understands the importance of providing the Department of Veterans Affairs the necessary tools and policies to serve the needs of veterans. This legislation ensures that wounded warriors returning from Iraq and Afghanistan can receive care in their home by providing caregivers the necessary benefits to stay at home and care for them full time. This is especially important in rural States such as my State of Alaska where obtaining a caregiver from remote areas is extremely challenging. In those areas, families take care of their injured servicemembers. To further help rural veterans and their caregivers, the bill includes provisions for caregivers who are severely disabled or require emergency care to seek medical attention at non-VA facilities without being billed. For a veteran in one of the many remote villages of Alaska, this is especially important, for they already face many economic challenges.

The bill takes other steps to alleviate shortfalls in rural veterans health care. Telemedicine program expansion, authority to collaborate with Indian Health Services and community organizations are just some of the additional efforts taken.

In addition to providing for caregivers and improving health care for
rural veterans. S. 1963 will finally require the Department of Veterans Affairs to identify and take action on shortfalls in health care for women veterans, mental health care, and outreach to homeless veterans.

The coalition of organizations supports S. 1963 as introduced by Chairman AKAKA. Unfortunately, one of my Senate colleagues disagrees with me and my other Senate colleagues and the 13 veteran organizations about this initiative and whom they believe. My Senate colleague has offered an amendment that almost doubles the cost. Although he claims the bill is discriminatory against veterans from previous wars, the expansion of rural women’s, mental health, and homeless initiatives are not limited to any particular group of veterans. Additionally, my colleague’s amendment offsets the cost of the bill by requiring the Department of State to transfer money to the Department of Veterans Affairs for U.N. peacekeeping operations.

Sitting here for a few minutes listening to my colleague, I have to say a couple comments that are not written here. First, my colleague, who voted for the war supplemental that had no funding offset, than to make the cost there and no offset to them, sent people to war. When you do that, you have to remember the costs associated over the long term. I wasn’t here during those votes. I wasn’t here when $1 trillion went to the richest of the rich for tax breaks that had not one dime of offset. I am paying for that. My son is paying for that. So it is interesting to hear this debate now.

We have to think long term. We have to think when we go to war, there are costs. If we don’t fund them on the front end, we have to deal with them on the back end. That is what we are doing now.

I think his amendment is worthy to a certain degree, but I disagree with the funding source. Listening for the last 2 minutes as a new Member surprises me. My Senate colleague is forcing us to make an inappropriate choice with this amendment that will cost us more in the long run. He is asking us to choose between providing for veterans and maintaining America’s essential role in the world. His amendment pays for the war supplementals that had no offsets. He is asking us to choose between providing for veterans and maintaining America’s essential role in the world.

My amendment offsets the cost of the bill by requiring the Department of State to transfer money to the Department of Veterans Affairs for U.N. peacekeeping operations. (S. 1963)

The PRESIDING OFFICER. Who yields time?

Mr. AKAKA. Madam President, I yield 3 minutes to the Senator from Montana, Mr. TESTER.

The PRESIDING OFFICER. The Senator from Montana, Mr. TESTER, is recognized.

Mr. TESTER. Thank you, Madam President, and I thank Chairman AKAKA.

Madam President, I rise this morning to urge the Senate to pass the Caregivers and Veterans Omnibus Health Services Act of 2009. Chairman AKAKA has done a great job of explaining the particulars of this bill. I thank him and Senator BURR for their leadership in our committee.

I could also echo Senator AKAKA in explaining the reasons to vote for better health care for this county’s veterans. But, instead, I am going to boil it down to one reason. Madam President, we promised it—we promised it—to those who have served in our military. We promised it, just as we promised our troops the resources they need when they are in battle. This is not a vote about politics or partisanship; it is about living up to the pledge we made to all our veterans.

Montana is a rural State, which means that all 100,000 veterans there are rural veterans. Many of them live in frontier communities. Sadly, that means they have a tougher time getting the care they have earned. Many of them still have to pay out-of-pocket travel expenses to get to a VA hospital for their health care. According to some studies, veterans who live in rural America do not live as long as veterans who live in urban places. That is not only sad, it is disgraceful, and it is unacceptable.

This bill contains provisions I included with the help of rural veterans and veterans service organizations in Montana. A vote for this bill is a vote for rural America and frontier communities better access to health care. A vote for this bill will lock in a sustainable VA mileage reimbursement rate for disabled veterans who have long distances to travel to get to a VA hospital. A vote for this bill will authorize the VA to award grants to veterans service organizations that drive veterans to their medical appointments. In places such as Montana, we would be in pretty tough shape without the dozens of volunteers who make that sort of thing happen. A vote for this bill will also improve health care in Indian country, and it will improve mental health care for rural veterans.

Last week, over Veterans Day, I had the honor of attending events across Montana. I had the opportunity to say thank you to our veterans, as we should do every day. A lot of veterans to whom I spoke last week made it clear—made it clear to me—we still have a lot of work to do to live up to the promises we have made to our fighting men and women. This legislation is the be-all and end-all, but it is a big step forward that is the result of putting politics aside and working together to do right by all of the men and women who have served our country.

Passing this legislation is living up to a promise. It is common sense. That is why I urge my colleagues to support it.

With that, Madam President, I yield the floor.

The PRESIDING OFFICER. Who yields time?

The Senator from Oklahoma.

Mr. COBURN. Madam President, may I inquire how much time I have remaining?

The PRESIDING OFFICER. The Senator from Oklahoma controls 112 minutes.

Mr. COBURN. Thank you, Madam President.

I want to go back to the start of this again. The American people need to know what a hold is. What is a hold? A hold is a time when a Senator puts a hold on a bill, so a Senator can either have no knowledge about what is in the bill, whether there is controversy about what is in it. As a matter of fact, they do not know that the bill on the floor is actually different from the bill passed out of committee. It has been modified, not with the vote of the committee but with the direction of the chairman only.

So the purpose of our holds is either you are against the bill—and I have no secret holds. Everybody here knows that. When I hold a bill, everybody knows the bills I hold, and I give a reason for why I hold them. I do not hold them sheepishly. The purpose for a hold is to develop debate, to have the very discussion we are having on the floor.

This bill was filed October 28. It was brought to the floor the week before
last without the ability to amend it, debate it, or discuss it. So the reason we are here today is so we can do just that.

I have stated numerous times—I have stated it to the chairman of the committee and the ranking member of the committee and others—I do not oppose—as a matter of fact, I am for providing for our veterans. What I am opposed to is us sinking our grandchildren in debt.

The Senator from Alaska makes the claim or insinuates that I was here when the tax cuts came through. I was not. I believe when you do tax cuts you match them with spending cuts.

There is $350 billion a year in waste, fraud, and abuse that goes through this government every year. Not one amendment out of over 600 that have been offered has been agreed to by this body to eliminate some of that waste—not one.

Everybody who has spoken against this amendment or for this bill, with the exception of Senator BURR, has a 100-percent voting record for keeping money. Not once do they vote against any spending bills, not once since I have been in the Senate—5 years. Not one of those who are opposed to paying for this has said: I see something wrong with this spending bill. It is not a priority. We ought to cut it. Therefore, I am not going to vote for it.

I have had criticism because the first year I was here I actually voted for a war supplemental. But at that time, we had a war with $1.10 billion, not $1.4 trillion. At that time, we had an economy that was growing, not an economy on its back. At that time, we had not totally mortgaged our children's future.

It is time for all of us to change. It is time for all of us to make the same decisions everybody outside of Washington has to make every day, which means you have to make a choice. You get to decide on what is a priority and what is not. For, you see, our body, the supposed most deliberative body in the world, has a bias. The bias is this: Offend no one. Offend no one. How do you do that? How do you offend no one? You offend no one by taking the government credit card out of your pocket and putting it into the machine and saying: We do not have to make those hard choices. We are not going to offend anybody by cutting programs.

We are not going to offend anybody with the $50 billion a year of waste at the Pentagon. The fact is, 2 years ago the Pentagon paid out performance bonuses of over $6 billion to companies that did not meet the performance requirements.

Sadly, not one American, not the Federal Government, got any of that money back. None of it came back because the other side of the story is, we fail to do oversight. We fail to do the hard work that does not give you a headlines. That is very hard work to hold the executive branch and agencies accountable. So our veterans do sacrifice.

I am for the Caregivers Act. I am for us doing all these things. But I am only for them if, in fact, we will start making the same hard choices our veterans make, the same hard choices everybody else in this country makes when it comes to making a decision about the future.

You see, a lot of people in our country today are underwater on their mortgages. They are underwater on their mortgages. Guess who else is. We are as a nation. We are underwater. Let me quote from this chart, for example, what the financial situation is with our country.

Medicare is broke. Part A will run out of money in 2017. We have 50 million baby boomers—I am one of them—who are going into Medicare in the next 8 to 10 years. So not only is the cost per Medicare patient going to go up, but we are going to add 50 million to it. It is broke.

Medicaid. It is broke. It comes out of your general tax revenue. But the States are broke over their share of Medicaid.

The census. It is broke. It is going to cost 2½ times what the last one did. It is total mismanagement by the Federal Government.

Fanny Mae and Freddie Mac—broke to the tune of $200 billion of your money, each one of them; $400 billion that your kids get to pay back, your grandkids. They do not get the opportunities because they are both broke. We have done such a wonderful job.

Social Security. It is the easiest to fix, but it is essentially broke because we have stolen $2.6 trillion from it. And then we are not being honest with the American public about what our true deficit is because when I said a minute ago that our deficit was $1.43 trillion, that is not true. That is Enron accounting. That is Washington accounting. The real deficit is well over $1.5 trillion because we stole more money from Social Security. Guess what. Next year, for the first time in the history of Social Security, more money will be paid out than will be paid in. For the first time, it runs in the red next year. We owe money, so technically it is not broke yet—until some of that $2-plus trillion goes back into it—but it is essentially broke.

How about the post office? They just announced their loss for this year. They are going to have a bigger loss next year. It is broke.

Cash for clunkers. That was broke when it started.

The highway trust fund. It is broke. We do not have enough money for what we are obligated to pay out. It is broke.

Now we are talking about government-run health care? A $2.5 trillion program? That is what the real number is on it when you get the Enron accounting out of the bill that Senator Reid introduced last night—$2.5 trillion.

And now we are saying we do not have the courage to pay to take care of our veterans. I do not think the American people are going to tolerate this much longer, nor do I think they should tolerate it—that we will continue to steal the opportunity and future of our children.

I think the Senator from Alaska can be counted among those who are opposed to the abuse, fraud, and waste in the U.N., because in every country he mentioned, U.N. peacekeepers have been accused of rape and pillaging the very people they were supposed to have been protecting. In every country he mentioned, U.N. peacekeepers paid for raping the very citizens they are supposed to be protecting. Yet we do not have the courage to say: Time out. We are not sending you any more money until you clean up the mess. No, we are not going to do that. We are not about to do that.

What we are going to do is we are going to say we will take the money for the veterans from our grandchildren and we will not make the hard choice. I think it would be a wonderful message to the American people that maybe they ought to start being transparent about where the money goes. Do you realize nobody can know where the money goes? You don't get to know. I, as a Senator, don't get to know. The President pro tempore doesn't get to know where the money goes. Yet your country puts $5 billion a year into that and you have no idea. The only way we find out is occasional leaks.

By the way, of all those U.N. peacekeepers who have raped and pillaged, not one of them has been convicted. Not one of the agencies, in terms of their eight programs that have been incompetent and wasted money, have been convicted. They are immune to conviction. The waste, fraud, and abuse of this country is only exceeded by one organization, and that is the United Nations. Yet we don't have the courage because the State Department is against this amendment, and they sent a letter outlining why they are against it. Mr. COBURN, you are going to read into the Record why they are wrong. I ask unanimous consent that at the end of these remarks, my rebuttal statement in response be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

(See exhibit 1.)

Mr. COBURN. The State Department Bureau of Legislative Affairs opposes this amendment. It lists a number of reasons as reasons to the U.N. and oppose the Coburn amendment. Many of the programs and activities the State Department listed have experienced severe problems in execution or are taking credit for activities by national governments or private entities.

Let's take the recent elections in Afghanistan. The United Nations cannot account for tens of millions of dollars provided to the Afghan election commission, according to a GAO audit—these are confidential; they were not released; we just happened to be fortunate enough to have people who would give them to us—and interviews with
current and former senior diplomats. The Afghan election commission, with over $20 million in U.N. funding and hundreds of millions of dollars in U.S. funding, facilitated and helped mass election fraud and operated ghost polling places.


This is a deputy to the senior U.N. official in Afghanistan. He was fired last month. He protested the fraud and he got fired by the U.N., that wonderfully competent organization.

As of April 2009, the U.N. had spent $72.4 million supporting the electoral commission, with $56.7 million of that money coming from the U.S. Agency for International Development. The Special Inspector General for Afghanistan Reconstruction states that the United States provided at least $283 million in aid for that election.

In one instance, the United Nations Development Programme paid $6.8 million for transportation costs in areas where no U.N. officials were present. We paid transportation costs, but no U.N. officials were present. Why did we pay it? Where did that money go? Where is the money?

Overall, the audits found that U.N. monitoring of U.S. taxpayer funds was “seriously inadequate.”

In other words, it is there, they send it out, they don’t have any idea, but you can bet well-connected people at the U.N. are making millions off U.S. dollars.

How about the monitoring of nuclear programs in North Korea and Iran? In 2002, the North Korean Government used United Nations Development Programme money—UNDP money or aid—to purchase funds is aid for them for development from the U.N.—they purchased conventional arms and ballistic missiles. With money we gave the U.N., the U.N. turns around, gives it to North Korea, and they buy missiles and arms. There is a real problem at the U.N. We will not face up to it.

It also transferred millions of dollars in cash to the Government of North Korea, with no oversight on how the money was spent—no oversight, just handed them millions of dollars in cash.

In September 2009, North Korea announced the processing was complete.

We helped finance it through the United Nations. We helped finance it through the United Nations.

As this morning, Iran had rejected the U.N. offer to send enriched uranium out of the country to prevent it from developing nuclear weapons.

We don’t know how much U.N. money has gone in there yet, but I promise I will try to find out. But I can guarantee that millions of our dollars have been wasted that could pay for our veterans or we can borrow it from our children.


U.N. peacekeeping operations are plagued by rape and sexual exploitation of refugees. From 1994 forward, 68 separate instances of rape, prostitution, and pedophilia—68 separate times—and we pay half the U.N. peacekeeping costs. We don’t manage the money; the U.N. manages the money.

What would happen if U.S. troops were doing that? Yet we have no control.

In 2006, reported BBC News: Peacekeepers in Haiti and Liberia were involved—we are involved—sex crimes. You can read that in the BBC News of November 30, 2006, if you want to look it up.

In 2007, leaked reports indicate the U.N. has caught 200 peacekeepers for sex offenses in the past 3 years, ranging from rape to assault on minors. Not one of them has been prosecuted, not one.

Just this month, Human Rights Watch reported that Congolese Armed Forces, supported by U.N. peacekeepers—support from the United Nations, they are really supporting the Congolese, with U.N. funding in Congo, have brutally killed hundreds of civilians and committed widespread rape in the past 3 months in a military operation backed by the United Nations. That is this month. Yet we continue to send billions of dollars every year to the United Nations.

Mr. DURBIN. Madam President, will the Senator from Oklahoma yield for a procedural question?

Mr. COBURN. I will be happy to yield for a procedural question.

Mr. DURBIN. I am interested in speaking on behalf of the bill, and I know the Senator has time allocated under the unanimous consent request. I wish to ask him at his convenience if he has a time when he would be able to yield to this side or is he going to speak and use all his time?

Mr. COBURN. I do not plan on consuming all of it at this time. I have about 10 or 15 minutes more to go, and I will be happy—is the Senator wanting time?

Mr. DURBIN. Could I ask unanimous consent that when the Senator breaks or prepares to yield the floor, at least temporarily, that I be recognized next? Mr. COBURN. I have no objection to that.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. DURBIN. I thank the Senator.

Mr. COBURN. Going back to the Congolese, most of the victims were women, children, and the elderly. Some were decapitated. Remember, these are U.N. peacekeeping forces—peacekeeping. Others were chopped to death by machete, beaten to death with clubs as they tried to flee.

They may not have been actual U.N. officers, but the U.N. was supplying all the logistics, all the transportation for this group of people. Where is the oversight?

U.N. contributions: Compiling forecasts of global agriculture production and identifying areas of likely famine and the risk of severe hunger, to facilitate food assistance. We make a contribution to the U.N. Food and Agriculture Organization is currently hosting a U.N. conference, a food summit in Rome, where the opening speaker is Zimbabwe President Robert Mugabe who has literally destroyed his Nation, which used to be the bread basket of Africa and which is now dependent on food imports. We are helping to pay for President Mugabe—who can’t travel hardly anywhere else in the world because he is such a rogue dictator—we are sponsoring, through our dollars, meetings where he is the head-line speaker.

The meeting was branded a failure within a couple of hours of its start after the 192 participating countries unanimously rebuffed the United Nations’ appeal for commitments of billions of dollars in yearly aid to develop agriculture in poor nations.

It is not because they don’t care about people having problems with food; it is they recognize the U.N. is ineffective at doing that and they are not going to commit more money, but we continue to commit more money.

The U.N. Environment Programme spends $1 billion a year—20 percent of it our money—on global warming and its effect on agriculture.

The U.N. has coordinated efforts by the global shipping industry and governments to prevent and respond to acts of piracy on the high seas.

It was totally ineffective. Do you know why we do our mount of piracy on the high seas? It is because of Task Force 51, which was formed by the U.S. Navy because the United Nations was totally ineffective in accomplishing that purpose.

I could go on and on. But the fact is, the United Nations is not only morally bankrupt in its leadership and efficiency, it is filled with fraud, waste, and, as noted, tremendous acts of violence through the peacekeeping armies it sends throughout the world. Yet we are going to have people say we shouldn’t take some of that money away. We are not taking all the money away with this amendment anyway; we are just taking a small portion to pay for our bill.

We are going to have people actually vote to continue to do these things, instead of taking care of our veterans and not steal it from our children.

I heard Senator Tester speak about the wonderful things in this bill to help people who drive to VA clinics and VA hospitals. There is a better idea. If a veteran is deserving of care, give him a card. Let them go wherever they want.
Why should they have to drive 160 miles, when they can get the care right down the street from somebody they trust and they know. But instead we say: We are going to promise you health care, but you can only get it here. Real freedom for our veterans is real freedom for our veterans to honor their commitment by saying: Here is your card, you served our Nation, go get your health care wherever you want. If you want to get it next door or if you want to go to the M.D. Anderson or Mayo Clinic, you can. You can go wherever you want because we are going to honor your commitment.

I recognize our VA hospitals have done a magnificent job in improving their care, but I will tell you the test for the VA hospital system is this: Go ask any doctor coming out of training who experienced part of their time in a VA hospital and ask them to choose for their family: Do you want your family treated at a VA hospital or somewhere else without any help from the government? You will pick a VA hospital because the care isn’t as good. It is better, and it is getting better all the time, but it is not as good. So we are saying to veterans: Here is where you have to go, when what we should say is: Thank you for your service. Here is what we owe you. Go get care wherever you want to get it or wherever you think you can get the best treatment.

On prosthetics, the VA is the best in the world. Nobody can argue. On post-traumatic stress disorder, they are the best in the world. Nobody can compare. They are underfunded in those areas. This bill is right on that. But the real commitment is to give the choice. The veteran fought for freedom. Give them the choice, the freedom to choose what they want for them.

Why is it important we change how the Senate operates in terms of making hard decisions? The reason it is important is there are millions of these little girls and little boys. There are five of them. One of her grandkids just like her. She has a little sign around her neck. She says: “I am already $38,375 in debt and I only own a dollhouse.” Of course, when you divide up the $12 trillion which we passed this week in directly owned debt, it doesn’t count the billions—I mean the trillions—we have borrowed from Social Security and the other trust funds, such as the waterway trust fund and all these other organizations we have stolen from the American people. But that is for every man, woman, and child in this country. It is over $30,000 now, this year. I think when you look at her, you have to say, certainly, we ought to be making some changes. By the way, between now and 2019, that number grows to over $96,000 per man, woman, and child. But she is a child. This doesn’t apply to veterans, but it applies to almost everything else we are doing.

This is what Thomas Jefferson said: The democracy will cease to exist when you take away from those who are willing to work to give to those who would not.

If you think about what is happening in our country right now and how things are being shifted, what we are doing is, we are on the cusp of a dramatic change in our country in terms of balance. This huge bill, which I will talk about later, is a major move in that direction. Senator Byrd and I were talking this morning about this. In this bill is a 5-percent tax on cosmetic surgery. Just the day before yesterday, the U.S. Preventive Task Force Services recommended—because it is not cost effective. If you want to pick the 50 not get mammograms unless they have risk factors. You tell that to the thousands of women under 50 who were diagnosed with breast cancer last year with a mammogram. Tell them it is not cost effective. But also in this bill is a 5-percent tax on breast reconstruction surgery after they have had a mastectomy. They are going to tax having their breasts rebuilt after their breasts have been taken off because it is an elective plastic surgery. It is an elective cosmetic surgery. We are going to have a tax on it because we have taxed elective cosmetic surgery.

We are in trouble as a nation because we have taken our eye off the ball. I see the majority whip is back. I told him I would be happy to yield. At this time, I will reserve the remainder of my time and yield the floor to the majority whip.

EXHIBIT 1
REBUTTAL OF STATE DEPARTMENT TALKING POINTS ON COBURN AMENDMENT 2785

The State Department Bureau of Legislative Affairs opposes the Coburn amendment to S. 1963, the Caregivers and Veterans Omnibus Health Services Act of 2009 (S. 1963). In its formal opposition, it lists a number of programs as reasons to support the U.N. and oppose the Coburn amendment.

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November 19, 2009

RESPONSE: The FAO (Food and Agriculture Organization) is currently hosting a U.N. food summit in Rome, where the opening speaker is Zimbabwe President Robert Mugabe. He delivered a fiery speech, blaming Western countries for their atrocities against the African people.

The U.N. Contribution: Enabling the delivery of food aid around the world (FAO).

UNITED NATIONS FUNDING

Caregivers and Veterans Omnibus Health Services Act of 2009 (S. 163)

Senator Amendment: Senate Amendment No. 2758 submitted by Senator Coburn to S. 163, To transfer funding for United Nations contributions to offset costs of providing assistance to family caregivers of disabled veterans.

Department Position: Oppose amendment.

Talking Points: U.N. assessed contributions fund a wide range of U.N. activities that support high U.S. foreign policy priorities. Some examples include:

- Facilitating and holding elections in Afghanistan and the Democratic Republic of Congo.
- Monitoring nuclear programs in North Korea and Iran (IAEA).
- Funding 17 U.N. Peacekeeping Operations, including those in Haiti, Liberia, Lebanon, Darfur and the Democratic Republic of Congo.
- Collecting forecasts of global agricultural production, identifying areas of likely famine and risk of severe hunger, to facilitate emergency food assistance (FAO).
- Coordinating tsunami and earthquake relief projects in Indonesia and Pakistan (U.N. Secretariat/OCHA).
- Detecting outbreaks of avian flu and H1N1 and other infectious diseases.</p>

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- Detecting outbreaks of avian flu and H1N1 and other infectious diseases (WHO, FAO).
- Creating and maintaining systems to protect the intellectual property rights of American entrepreneurs (WIPO).
- Enabling the delivery of mail around the world (UPU).
- Coordinating international aviation safety standards (ICAO).
- Coordinating global use of electronic communications frequencies to ensure essential global telecommunications function smoothly (ITU).
- Coordinating efforts by global shipping industry and governments to prevent and respond to acts of piracy on the high seas (IMO).

Furthermore, the President has stated his commitment to paying U.S. dues to international organizations in full. As Ambassador Rice has said, we meet our obligations. As we call upon others to help reform and strengthen the U.N., the United States must do its part—and pay its bills. Our dues to the U.N. and other international organizations are treaty obligations, and we are committed to working with Congress to pay them in full.

With the support of Congress, the U.S. has just cleared our arrears which accumulated over the past decade. The full payment of assessed contributions affects the standing and influence that the U.S. has at these organizations. Going into arrears undermines U.S. credibility, particularly on matters dealing with budget, finance, and management of IOs, and negatively influences world opinion regarding U.S. respect and appreciation for the role of multilateral organizations that support and advance U.S. foreign policy. Arrears also have a real impact on the organizations, making it more difficult for these organizations to manage cash flows and execute budgets, and thus accomplish their missions.

The PRESIDING OFFICER (Mr. BURRIS). The Senator from Illinois is recognized.

Mr. DURBIN. Mr. President, I thank my friend and colleague from Oklahoma. Although we disagree on many things, we also agree on many things. We work together and will continue to do so.

We have a difference of opinion on the matter before us. This bill, S. 163, is the most important piece of veterans legislation this year for several reasons. I congratulate Chairman AKAKA and Ranking Member BURR for bringing this matter to the Senate with a unanimous vote in committee, with both Democrats and Republicans supporting it, and for good reason.

In addition to the provision that was previously mentioned earlier today, there is a dramatic change in the law to help women veterans. More and more returning veterans from Iraq and Afghanistan and around the world need special care. Unfortunately, the VA system wasn’t providing that care as we believed it should. This bill takes care of that. It is the most dramatic expansion for women veterans and their health needs we have seen.

The same is true for rural health care. Our rural veterans—those who get the VA health care behind the scenes, who are working on the frontlines in Afghanistan and Iraq and around the world—need special care. Unfortunately, the VA hasn’t been able to provide them the care they need. This bill addresses that problem.

The same is true for mental health issues. It is an excellent bill. The part of the bill that is near and dear to me relates to caregivers assistance. It relates to the fact that many veterans who come home are not in institutional settings, but are at home. They are in the setting of their home where they feel secure and happy.

Great sacrifices cannot tell you exactly how many of these caregivers there may be. Estimates range as high as 6,000 or 8,000. I have met some of them, and I know them personally. I have heard their stories. They are heroic—just as heroic as the veteran who needs their care. They are literally giving their lives to keep that veteran alive, healthy and happy, at great personal sacrifice. Many times they cannot go to work. Many times they have to give up a business because they want to stay home with that husband they love.

A young woman came into my office the other day who is moving from Colorado to the Chicagoland area after more than 5½ years. She has been the caregiver for her husband who was the victim of a traumatic brain injury in Iraq. For this young woman, who is in her thirties, it is an amazing show of love and sacrifice on her part.

We have also spoken of the family in North Carolina we know very well—the
family of Eric Edmundson, a young soldier who was the victim of a traumatic brain injury. He is alive today—I can say this without contradiction—because his dad quit his job, sold his business, and cashed in the value of his home. With his wife, they moved to take care of their son and little granddaughter. That is the most loving family I can remember seeing, and they are doing it for the son they love, but they are doing it, as well, for a veteran who served our country.

The purpose of this bill is to give these caregivers a helping hand and the medical training they need so they can do what is necessary to keep that veteran alive and as well as possible, improving if possible. It is also to give them a respite maybe for a week or two each year so they can go on vacation and have a visiting nurse or someone who will come and provide assistance. They need that with the stress and burden they are carrying. That needs to be lifted temporarily—so they can recharge their battery and come home and be dedicated once again.

In the discretion of the Veterans’ Administration, it can give a monthly stipend or health care as well. The first thing I want to address is a provision in this bill when they sold the business was that they couldn’t afford to buy health insurance. Mom and dad are taking care of their son under the care of the Veterans’ Administration, and they have no health insurance. We are trying to find a way to provide health insurance for these caregivers. In my mind, it is simply fair and right that we would do this. That is why I thank Senator AKAKA and Senator BURR for including it in this bill.

I also want to address the issue before us, the pending amendment by the Senator from Oklahoma. The Senator from Oklahoma has come to the Senate floor several times and expressed his opposition to this bill, primarily for budgetary reasons. I understand that. But I say to him I was worried this day would come. I was worried the day would come when the war, which we paid for by borrowing money, would generate victims and veterans who needed care, and when it came time to give them the care many of the people who voted to fund the war by going into debt would say: But we can’t help the veterans unless we pay for it. In all the family.

If we vote to go to war, we vote to accept the consequences of war. That means an obligation that we have to these veterans. It is a solemn promise we gave them. We said to these men and women if they would hold up their hand, take an oath to defend the United States and risk their lives, we would stand by them when they come home. If they are injured, we will be there. If their family is disadvantaged, we will do our best to help them too. I think that is part of our solemn obligation to these veterans.

Now the question is raised as to whether we can afford to do that, unless we come up with a sum of money to pay for it at this moment. I say to the Senator from Oklahoma, and those who take his position, if we paid for this war to start with by borrowing money, how can we turn our backs on the caregivers who keep them alive arguing that it is simply budgetary justice? It is just not. It doesn’t track. I don’t believe those two approaches are acceptable.

Also, the Senator from Oklahoma does two things. In this amendment I wish we could do—one I wish we could do. I have talked to him about it on the Senate floor—and that is to expand coverage for caregivers of those who served before 9/11. I would like to do that. Currently, we believe there are about 20,000 caregivers who would qualify for this caregiver amendment, this demonstration project. If we expand it to all veterans caregivers, the number rises to over 52,000. It is a just thing to do. It is something we may ultimately have to do. But clearly, if we are going to make that commitment, it is a dramatically larger commitment than this demonstration project, this bill for those who suffered serious injuries since 9/11. To increase the scope of it from caregivers of those who served before 9/11 to caregivers is to increase the cost of it dramatically. That is something we have to measure and decide at some point—whether we want to do that.

I will work with the Senator from Oklahoma on that. I think all veterans’ caregivers deserve this. I hope we can prove with this approach that it is a reasonable thing to do—that keeping these veterans home where they want to be, in a safe, happy surrounding, is not only right but is cheaper than institutionalization.

The second part of Senator COBURN’s amendment related to this provision says the money would be available for caregivers if the veteran would otherwise need institutionalization. I think that may be drawing a line that is too harsh. I think there are those who need the help of a caregiver but may not technically need to be institutionalized. I think those who are suffering from post-traumatic stress disorder, a traumatic brain injury with seizures—say they need to be institutionalized may be overstating. To say they need the help of a caregiver and then move forward to treatment, I understand that. But here is my point; I think the Senator from Oklahoma expanded this bill from 2,000 to 52,000. On the other hand, he draws a line on institutionalization that may go too far. I think what we ought to do in this demonstration project is give the VA the authority to measure this and see what is appropriate. I think there are so many individual cases that, when we generalize like this, it is a mistake.

The Senator from Oklahoma believes the money to pay for this should come from the money set aside for international peacekeeping through the U.N. I will not stand here in defense of U.N. peacekeeping forces there, the massacres of innocent people would go unchecked.

This has been going on for over a decade. During this period of time, innocent men, women, and children have been literally hacked to death and killed. The international peacekeepers make a difference there. They make a difference in Haiti where I visited twice and have seen firsthand the degraded poverty in our own hemisphere and, unfortunately, the fact they are on the verge of violence almost every moment.

I also think it is a mistake for us to cut back on those international agencies that monitor the spread of nuclear weapons. If we want to keep an eye on Iran and make sure they don’t develop nuclear weapons to threaten their neighbors in the Middle East and the rest of the world, we need this international force to come in and do its inspection work. They are the only credible third parties that can come in and decide whether the Iranians have gone too far. Their judgment through the United Nations is one that is credible to other nations. To cut back in their efforts at monitoring the spread of nuclear weapons is, in my mind, shortsighted and invited instability in a world that is already too dangerous.

I urge my colleagues to defeat the Coburn amendment. I say to my friend from Oklahoma, at the end of the day, after we start this program, if the Veterans Administration can find the resources through the appropriations to move it forward, I am open to working with him to expand it to caregivers from previous generations of veterans and to see if there is a way to make sure it is spent exactly where it is needed and as we have described it.

That is the nature of this work. We are not perfect in what we do, but we start with good intentions and hard work and try to put the language together. But at this moment, I say to the Senator from Oklahoma, first, I am glad he no longer put a hold on this bill. It is an important bill. I am glad he has had his chance to offer his amendment. I urge my colleagues to defeat it, but I say it in good faith to my friend from Oklahoma.

I will work with him on this bill, in fact, the enacted law and implemented to make sure it meets the goals we both share—fairness to all veterans and providing care to those who need
it. This is a good start, but let us promise to work together, if it is enacted, to make sure we continue in that vein. I yield the floor.

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. BURR. Mr. President, the majority whip is a formidable orator and he is appreciated in lots of ways. We work together on subcommittees on the Judiciary Committee. I have a fondness for him. Although one area he did not agree to work with me is to pay for it.

Never have I said I don’t want us to do this for our veterans. Not once. The reason we are on the floor, the only reason we are on the floor having this debate is because of my hold; otherwise, we would never have gotten here to have the debate which I think is valuable for the people in this country.

But there has to come a time—every time I offer an amendment on this floor, a good time—when we start making our choices. That is what we hear all the time. Over 600 times in the last 4 1/2 years, it is never a good time to start making hard choices. That is just what we heard.

The Senator from Illinois referenced Congo. Just this month the Congolese army, with the assistance of the United Nations, slaughtered a bunch of people. And we are supposed to continue?

I put two other things out there. Under Federal law, the Accountability and Transparency Act of the Senate, the United Nations is required to tell the American people how our money is spent because the State Department is required to find it out and put it online. They have refused to do it. So we have no idea what it is.

Two years ago in the Foreign Ops bill, an amendment was agreed to by 100 Senators that there would be transparency. Our money going to the United Nations would be conditioned on the fact that the United Nations would be transparent on how it was spent. That was voted 100 to 0 in the Senate.

Guess what happened on the way to the bank coming out of the conference committee. It was eliminated. So now we send over $5 billion directly, $5.2 billion, plus billions more through USAID through the United Nations, and we do not have any idea how it is spent.

What we do know is that the United Nations has been and continues to be bankrupt. It is loaded with fraud, loaded with duplication, and loaded with excess.

It would be a wonderful thing to send the United Nations a wonderful fire shot across the bow that they have to start being accountable for the dollars that the American taxpayer, that this little girl is sending them out of her future every year. It would be a wonderful thing for us to say that.

It is unfortunate, every time when we go down to the point where we have to make a hard choice, we always choose not to make the hard choice. That spells disaster for our country, and it also spells a total lack of leadership on our part to recognize what the real problems are that are confronting this country.

Our veterans deserve us to take care of them. I am for that. Our children deserve for us to do it in a way that protects their future, the every thing for which our veterans serve.

Unfortunately, we will not do that with this amendment or any other time until the American people decide that they want to put the careengriment, the elitism, the lack of integrity, the lack of courage that is so often represented in the votes we cast in this body.

I reserve the remainder of my time, and I yield in my absence any time the Senator from North Carolina wishes to take from my time.

The PRESIDING OFFICER. The Senator from North Carolina.

Mr. BURR. Mr. President, I wish to be recognized for the remainder of the minutes I currently have available to me, and if the clerk will notify me at the end of that time, then I will go into Senator Coburn’s allotted time.

The PRESIDING OFFICER. Without objection?

Mr. BURR. Mr. President, I wish to reiterate, as the ranking member of the Veterans’ Affairs Committee, this bill was reported out unanimously. I think it will receive unanimous support in its passage later this afternoon in the Senate.

Let me restate for Members, when the committee passed this bill out, we passed it out with all caregivers being included. It was after the committee reported out that we narrowed it to OEF and OIF veterans and their caregivers. It was the intent of the committee to include all the people Senator Durbin, the majority whip, said we might consider later on but not now. The committee’s intent was let’s do it in the bill now.

It was also the committee’s intent that these were individuals who were targeted for us to provide this caregiver benefit to so we can keep them out of nursing homes because of the Ted Wades, because of the Eric Edmundsons.

Senator Coburn’s amendment is consistent with the bill that was passed out of committee unanimously. The bill says the Secretary “shall,” therefore, have means he has to. The Secretary will then have to prioritize spending within the Veterans Administration to fund these programs. The third piece of what Dr. Coburn’s amendment does is rather than force the Secretary to prioritize within just VA programs, meaning there are going to be veterans who win and veterans who lose, why not say as a Congress: Why shouldn’t we do what we are supposed to do? Why should we not prioritize the spending here?

What my good friend from Illinois suggested was why should we prioritize for the United Nations? Let me say the answer is quite simple: It is our money.

The suggestion that the Congress doesn’t have a fiduciary responsibility to fund programs we implement at a time we are borrowing 50 cents of every dollar we spend is ridiculous on its face.

I suggest that the Senate, the Congress can operate any differently than a family in America suggests that we ignore the input of everybody who asked us to represent them. We do represent the American people, 100 individually who represent the entire country. How can we do it differently than any family who is out there struggling to meet their end-of-the-month obligations and when their revenue does not meet their expenses? What do they do? They either cut their expenses or they find a place to raise more revenue.

Let me suggest this is as simple as, Is it time for us to prioritize where we are placing money? Members will have to decide: Is pulling money from the United Nations an appropriate place for us to pull money from to then spend on our country’s veterans?

I believe we have an obligation, I believe we have a promise, even for programs that did not get to us this time, that when we see it is in the best benefit of the quality of life of our troops, that we provide that benefit for them. But I believe we also have an obligation to this generation and the next one and the next one to pay for it.

This is not a choice that is tough for Members. If you support the Coburn amendment, you support practically everything the committee supported without the 100 Senators that we passed the bill unanimously consent. If you support the Coburn amendment, you believe we have an obligation to pay for it. The only reason you would vote against the Coburn amendment is because you don’t think it is appropriate for us to deprive the United Nations of this money to use as they see fit.

I suggest this is where the disconnect is with the majority of America. They would prefer the Senate to decide where that money went and to use it on these caregivers and these veterans programs.

I encourage my colleagues to support the Coburn amendment, support passage of this bill this afternoon when we take it up.

I wish to shift gears slightly because I think it is somewhat ironic that we are talking about expansion of services to our Nation’s veterans at a time where the American population is in a bill that, in all likelihood, will deprive other Americans of the ability to have affordable health care.

We have gone through several months of debate now about health care that money and affordable for all Americans. We have talked about reforms; let’s change the system; let’s reform the system; let’s make it accessible and affordable; let’s bend the cost curve down. In the last 24 hours, some have come and said we have accomplished that, it is amazing.

Let me remind my colleagues, we have all said health care is
unsustainable in its current level of investment. 17 percent of our gross domestic product. I find it somewhat odd that we would start the debate given that it is unsustainable in its current financial investment with how much more money does it cost to reform health care? The obvious answer is it should cost zero. If you are already spending too much, we should look at the reforms before we look at the coverage expansion.

I urge every American ought to be covered. As a matter of fact, Dr. COBURN and I have offered comprehensive bills to do that. But it is matched with real reform.

What was heralded in the last 24 hours is, in fact, a $2.5 trillion health care bill—$2.5 trillion—over a 10-year period of collecting the revenues and paying out the expenses. This is where gimmicks, smoke and mirrors—whatever you want to call it—are used in Washington. If you collect revenue for 10 years but you only pay benefits for 6 years, you don’t get a true picture of what it is going to cost over 10 years. You get a true impact of the revenue stream which is over $800 billion.

From where will that $800 billion in new revenue appear? Taxes. They go up stream which is over $800 billion. You get a true impact of the revenue what it is going to cost over 10 years. But you only pay benefits for 6 years. If you collect revenue for 20 years before we ever pay out the first dime. It is not hard to understand why you would have a $72 billion surplus out of this.

Now ask, what happens after that? What happens after the $1/2 billion past that 20-year number? The truth is, it starts to get into the trillions and trillions of dollars for which the Federal Government is obligated, based upon the premiums and the benefits people have assigned to it, that they pay out.

If you eliminated these two gimmicks, just on its face this bill would be $189 billion out of balance, in the red. It would not be paid for.

Let me suggest that is smoke and mirror tools. The start date was moved from 2013 to 2014. No longer is our focus on how do we get care delivered as quickly and as efficiently. We just pushed it off a year because we said the Congressional Budget Office says we cannot raise money, and we have raised all we can in fees and taxes. Maybe not all. I think they probably have some things targeted that are still yet to come out. The key thing is, even if you did implement it, there are 24 million Americans who are still without insurance. The objective to cover everybody was not met. There are $25 billion worth of unfunded mandates to our States. I don’t know of a State that is in financial health today.

Let me suggest to my colleagues this bill is $2,074 pages. I will admit—I may be the only one—I have not read it since it was introduced at 6 o’clock last night. I am not sure there are many Members who have or could have. But let me suggest there will be a question of eligibility and we use taxpayer money to perform abortions. Personally, I believe that is wrong. I will not support a piece of legislation that does that. This bill does that.

An employer mandate, at a time when American companies are trying to be competitive in a global marketplace? We raised $28 billion in employer mandates. I am not sure that is making U.S. companies more competitive in a global marketplace. I think the economy is the No. 1 challenge we have in America. I think 10.2 percent unemployment and going up—if it were a disease, we would be on the floor of the Senate calling it an epidemic and we would be spending whatever to help turn it around. But we are doing nothing. As a matter of fact, we are doing everything we can to try to drive up unemployment, to dry up the economy, and to make companies less competitive in a global market.

The President said one of the objectives of health care reform was we need to bend the cost curve down, we need to make sure there are cost savings in health care. Everybody has told me how much this would save. Let me tell you what the Congressional Budget Office says:

Under the legislation, federal outlays for health care will increase during the 2010–2019 period, as would the federal budgetary commitment to health care.

That is Washington language for: You know what. Our expenditures on health care are going to go up. What happens when Federal expenditures go up? Everybody’s go up, that is a known quantity. And the CBO score a $72 billion savings. Let me explain it like this: Nobody qualifies today because it doesn’t exist. People are going to pay premiums to be eligible for this long-term benefit. It takes about 20 years of paying in before somebody is going to be eligible to pull it out. It is not similar to Medicare, when we created it, where, even if you never pay into it, you can get the money out of. We are collecting revenues for 20 years before we ever pay out the first dime. It is not hard to understand why you would have a $72 billion surplus out of this.

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There may be one or two.

My State of North Carolina was $4 billion out of balance. Last year, the Federal stimulus was $2 billion of closing the gap. That $2 billion, by the way, we didn’t have. We borrowed to get it and we put that $2 billion back in to the States to create jobs. It was used to close budget gaps so they didn’t have to make tough decisions. As a matter of fact, we found out this week, on one of the news channels, there is $36 billion that didn’t have anything to do with stimulus.

We are the laughingstock of the world on the way we applied the stimulus package. But the sad part is not the fact that it has been uncovered, it is the fact that it didn’t put Americans to work. Now we are saying to the States we are going to put another $25 billion on you.

In Medicare, we are going to cut from the fee-for-service payments $192 billion. So we already have $227 billion over here that we are getting from doctors if we go through with the payment cuts. Now we are targeting another $192 billion out of Medicare reimbursements, right out of the pockets of doctors and hospitals. Is there a community hospital in this country that will be able to survive, given the cuts that are getting ready to hit them? We cut Medicare Advantage $118 billion. Some
Members: Support the Coburn amendment on the veterans bill. Support passage of the veterans bill. Read the health care bill. Be prepared to debate the health care bill for a very long time and be prepared to stand for the American people on what is right.

I yield 20 percent of our Nation’s seniors when they lose Medicare Advantage? What about the $43 billion in DSH, disproportionate payments, we pay the hospitals to make up for the uncompensated care they deliver? I guess the authors of the bill would say we are covering everybody so there is no uncompensated care. Wrong; 24 million are still without health insurance. There is going to be uncompensated care, and we are taking away the money we are providing the hospitals to make up for the uncompensated care they delivered, meaning it is coming right out of their pocket. Anyone in the community we live in: $23 billion in unspecified cuts by the Medicare Advisory Board. Is America comfortable with turning to another advisory board to cut $23 billion? We just had an advisory committee. If you are over 60 and you are female, you don’t need to worry about your breasts, don’t need to go get a mammogram, don’t need to do self-examinations—trust us.

One of the reasons the health care system in America is the best in the world is because we spend money to innovate. We hope companies find breakthroughs. We look at diagnostic abilities in an effort to try to detect early, so the illness is greater and the cost is less. But now, all of a sudden we are saying that is not important.

There are 162 million Americans who currently have employer-based health care. In this bill, regardless of what that employer does, they will not be eligible for subsidy. If they currently have coverage but they may be below income and for some reason their employer has to drop their health care or cut back on the plan because—maybe they need to be more competitive and so the cost is less. But now, all of a sudden we are saying that is not important.

The health care of our citizens may be the most precious of all things to every person and every family. We are a democracy and the American people have a right to be heard on all issues but especially on this type of issue. We should be given the opportunity to read and hear what is in this bill, to hear it discussed, to hear from our constituents because it ought to be on the Internet. That is why we have the Internet access to bills that are introduced in the Senate. But by the time our constituents have a chance to read it, we will have already had a vote on whether to proceed to the bill.

Even after a cursory review, I know this bill includes changes that are disastrous to families, health care providers, and the economy. Higher taxes, mandates—especially for small businesses—penalties, cuts to Medicare, higher premiums, restricted choices, a government plan—the list goes on. The bill includes almost $1 trillion in taxes, including a new Medicare payroll tax; penalties for employers who don’t buy coverage; $149 billion in taxes on employers who don’t offer the right percentage of coverage to employees; $102 billion in taxes on insurance plans, pharmaceutical companies, and medical device companies which study showed will be passed on to the people who get these services and equipment.

To make matters worse, the bill includes almost $1 trillion in cuts to Medicare. It is guaranteed to reduce choices and coverage for seniors. In my State of Texas, 400,000 people love their Medicare Advantage, or at least they have it and are satisfied. They will lose Medicare Advantage under this bill. The Democrats are touting the cost of the bill as meeting the President’s goal of being under $1 trillion because CBO scored it at $849 billion. But this is a budgetary sleight of hand, because what is actually being scored is the bill costs $2.5 trillion, not $849 billion.

Given more time to analyze this bill, who knows what else we would discover? If the Democrats think this is the reform Americans wanted, why rush the bill through the Senate? Why rush it through before we have the ability to review details?

The right approach is available. My colleagues and I have proposed commonsense and fiscally responsible ways to bring affordable access to health care. We need to do that. We have never said we don’t need reform. What we have said is we need reform that will give more affordable access for coverage to Americans who do not have the access today.

We should reassess the goals of health care reform and implement policies that we know will reduce costs. For sure, reducing frivolous lawsuits, Study after study has shown how inefficient medical malpractice reform. In Texas, we have tort reform. We have seen a dramatic increase in physicians who are willing to practice medicine. It has lowered the cost of medical malpractice premiums, and doctors have been able to do their work with their patients with much more freedom, knowing they do not need to order unnecessary tests just to cover themselves in case they get sued. The majority insists on rejecting this suggestion. It is in this bill. We have medical malpractice reform. In the Senate, we have tort reform. We have seen a dramatic increase in physicians who are willing to practice medicine. It has lowered the cost of medical malpractice premiums, and doctors have been able to do their work with their patients with much more freedom, knowing they do not need to order unnecessary tests just to cover themselves in case they get sued. The majority insists on rejecting this suggestion.

I will offer an amendment, or at least prepare one and hope to be able to offer it, that would cap damages, reduce malpractice premiums, and encourage doctors to practice in medically underserved areas, especially rural areas, have no doctors. There are counties in Texas that don’t have a doctor within hundreds of miles and several counties. That is because the medical malpractice premiums are so high, they cannot afford to do it.

The small business premiums are going to go up, if this bill is passed. Small businesses already have a hard time offering coverage to their employees. Why would we make the problem worse, especially when we have the highest unemployment in decades? We should be allowing small businesses to pool together and buy plans. We have...
championed that proposal for years in the Senate, but we have never been able to get over the hurdles to pass a small business health plan. If we could do that, we could spread the risk. The bigger risk pools would produce lower premiums and allow more small businesses to pool to offer their employees affordable health care coverage. Allowing businesses to pool doesn’t cost the government anything. Therefore, it would not require tax increases, as we see in the bill before us.

The Democrats are trying to address the problem of unaffordable insurance by offering credits to small businesses to offset the cost of premiums. But the credit only lasts for 2 years. That is hardly anything that is going to encourage businesses to take on the added cost when the credit lasts for 2 years. I will be preparing amendments that at least double that to 4 years, expand the eligibility and duration of these credits so we can help small business for even 4 years is not enough. We should offer credits all the way through.

Offering tax incentives. There are small businesses and individuals in this country who have no access to affordable health care. They are not going to give every individual who purchases their own health insurance the same tax break a corporation gets for offering health care coverage to their employees? Employees who receive insurance through their employer do not pay taxes on the premiums they spend for insurance. Why should individuals who purchase their own health care coverage be treated differently? I have a bill, with Senator DeMINT, that will help provide insurance for more Americans through tax credits and competition. Our approach would be a tax credit for every individual, $2,000 per year, and for families $5,000 per year for their purchase of health insurance. This would allow individuals to purchase their own coverage 2004 and would not have to be affected by what their employer offers or if they change jobs. This is the kind of reform that could make a difference.

How about creating a transparent marketplace online for consumers to go in and shop and hopefully have bigger risk pools, more competition, bringing the cost down? That is not the kind of marketplace that is in this bill. This exchange has so many mandates on the plans that, like the Massachusetts exchange, it would raise the cost of premiums and would not help in any way bring the cost down so that premiums are more affordable.

These are the ideas that would improve the competition in the marketplace. I can tell you, from the input I have received from my constituents since the bills have been out of committee, before the bill came to the floor or is on its way to the floor yesterday, it was cause to turn committee, that wrote bills that were put together and released yesterday, I have listened to what people say. I can tell you they don’t want Medicare cuts. They don’t want more taxes. Small businesses certainly don’t want more mandates. They don’t want government-run insurance. They know that a government plan is eventually going to crowd out the private insurance company plans through higher taxes.

I am going to be preparing an amendment that will allow States to opt out without penalties, not just of the government insurance plan but of all the harmful mandates we have put into a government opt-out by States, if they are going to still have to pay the higher taxes, if they are going to have to pay higher premiums to pay for the other States that have the plan? States should not be forced to participate in the government plan, nor subsidize and pay for such a plan through increased taxes.

I will prepare amendments that will exempt individuals and employers from the mandate to buy insurance, if this bill comes to the floor. I have a provision, if the bill can be above their currently projected values.

The solution to health care issues is not to give more power to the government. The solution is to give more power to the American people. They deserve to be able to purchase their own health care coverage. America will have the best health care in the world.

Which brings me to the new government task force that came out this week that is causing concern at best. It did not do the guidelines regarding screening for breast cancer. Breast cancer is the second leading cause of death in women in this country. Whether and when to screen for breast cancer has been debated for decades. It turns out, studies are now beginning to see the handwriting on the wall. The President said in the last 15 hours. I am so worried we are now beginning to see the handwriting on the wall. The President said once there is no reason we should not be catching decreases such as breast cancer and colon cancer before they get worse. It turns out, there is a reason: cost.

The insurance companies have sort of said in the last day or so that they are not going to stop the coverage of mammograms for women starting at the age of 40. But when the government plan comes into effect, you know that every insurance company is going to say: If we are going to be competitive, we must adhere to the same standards as the government plan. It is going to happen.

We must have time to look at this bill. We must have time to look at what is happening, to the health care, to Medicare. The cuts in services, the taxes, the mandates are going to overhauls our health care of our country. We must have time to look at this bill before we have a month and a half left that the President will be studying it. We must let our constituency study it because they will catch things they care about and they will inform us, and that is why we are here.

So I am very concerned that we are pushing too fast on something we should be taking slowly and carefully to assure we are not going to do something we are not sure is right, and review the data with health care spending in mind. Nearly everyone realizes that fewer screenings mean insurance plans, including a government-run plan, will save money.

This is how rationing begins. I hope America wakes up. This is how rationing begins.

In an article by the Wall Street Journal today, they recognized that. It reads:

Every Democratic version of ObamaCare makes this Task Force an arbiter of the benefits that private insurers will be required to cover as they are converted into government certificates. What recommendations will become de facto rules, and under national health care these kinds of cost analyses will inevitably become more common as government decides where finite tax dollars are allowed to go.

That is a quote from the Wall Street Journal today. The American Cancer Society came out with this incredible recommendation and said, with its new recommendations, the task force is essentially telling women that mammography at age 40 to 49 saves lives, just not enough of them. So if the screening is not going to save your mother’s or your sister’s or your wife’s, would that screening be worth it?

Decisions about care must be between a doctor and a patient, not a doctor who has a loyalty to anyone but the patient, not a doctor who is working for the government and having to maintain government task force guidelines, such as the one we have just seen.

That is the crux of the debate on this health care bill that has been released in the last 15 hours. I am so worried we are now beginning to see the handwriting on the wall. The President said once there is no reason we should not be catching decreases such as breast cancer and colon cancer before they get worse. It turns out, there is a reason: cost.

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where we have the chance, to change what we see is wrong.

Thank you, Mr. President.

The PRESIDING OFFICER (Mr. Udall of New Mexico). The Senator from Arizona?

Mr. KERRY. Mr. President, I wish to compliment the Senator from Texas for sounding this warning. Being from Texas, she is undoubtedly aware of a great country-western song out right now by Brad Paisley called “Welcome to the Future.” I think we have seen a glimpse of the future under Obamacare here by this pronouncement of the U.S. Preventive Services Task Force recommending against the routine screening of women between ages 40 and 49 for best cancer.

I want to speak for about 60 seconds about this issue to go into the actual numbers from the study to which Senator Hutchison referred. The rationale of the study is that you would need to screen 1,399 women in their fifties to save 1 life, screening is not worthwhile. But since you would need to screen 565 additional women—in other words, 1,904, to be precise—in their forties to save 1 life, screening is not worthwhile. That is the kind of cost-benefit analysis that is rationing, and it is precisely Senator Hutchison’s point that this is how rationing begins.

Welcome to the future.

Mrs. Hutchison. Mr. President, if the Senate will yield, I appreciate him giving us these statistics because it is 1 life out of 1,904 to be saved, but the choice is not going to be yours; it is going to be someone else who has never met you, who does not know your family history.

That was in the Clinton government reform, takeover of health care in 1993, and it was soundly rejected. It was soundly rejected. It was part of the reason it was soundly rejected—this mam-mogram rationing before the age of 50—but it was not just women who were against it and every woman in the Senate at the time rejected—rejected—that plan, rejected keeping women under the age of 50 from having mammograms paid for by insurance plans.

So I thank the Senator from Arizona for connecting this and showing the statistics because this is not the American way of looking at our health care coverage. It is not the American way, and we must stop this government takeover of health care.

Mr. President, I yield the floor.

Mr. KERRY. Madam President, I speak in opposition to amendment No. 2785 to the Caregivers and Veterans Omnibus Health Services Act. This amendment, offered by Senator Coburn, would cut funding for international organizations, including U.S. contributions to NATO and the United Nations. This would gravely undermine our vital national security interests at a critical time. We all strongly support strengthening our national defense and protec-tion of our nation’s veterans, but Senator Coburn’s amendment sets up a completely artificial choice between protecting the health of America’s veterans and ensuring that our Nation meets its national security objectives and international obligations.

To be clear, this amendment would cut funding from the contributions to NATO, which provides the assessed dues to the U.N. and NATO, APEC, OAS, OECD, and the OPCW, as well as taking funding from the contributions to international peacekeeping operations account. That is why I oppose this amendment, for several critical reasons:

First, we obviously need as much support as we can get from our NATO allies for our joint mission in Afghanistan. We cannot, and should not, carry this burden alone and how can we ask NATO to do more while we are at the same time cutting our NATO contributions? This would seriously undermine our standing with NATO and with our NATO allies at a time when we can least afford it. We simply cannot allow that to happen.

Several other international organizations are also threatened by this amendment. Funding for the Organization of American States, which addresses threats to hemispheric security, from terrorism to narcotics, would be cut. The Organization for Economic Cooperation and Development, which promotes economic growth in 30 member states and more than 70 developing countries, would lose funding.

The Asia-Pacific Economic Cooperation, which promotes trade, security, and economic growth throughout the Asia-Pacific region, and which the United States will host in 2011, would also be cut. The Organization for the Prohibition of Chemical Weapons, which ensures worldwide implementa-tion of the Chemical Weapons Convention, as well as the World Trade Organization, which provides the stable framework for international trade that is so critical to the United States, would suffer funding cuts.

Second, our United Nations contributions fund a wide range of U.N. activities in support of key United States foreign policy priorities. U.N. organizations are monitoring nuclear programs in North Korea and Iran. We need the best information possible about the nuclear programs in Iran and North Korea, and the last thing we need to be doing is cutting funding for the very organization that is doing on-the-ground monitoring. The U.N. is also providing vital assistance for the upcoming elections in Iraq, which will be critical to the future of democracy there. U.N. food and agriculture agencies are combating food insecurity and food insecurity and facilitating emergency food assistance. U.N. health agencies are on the frontlines of detecting outbreaks of avian flu and H1N1 and finding and working to contain the disease. In addition, we work through U.N. organizations to protect a range of U.S. interests, from the intellectual property rights of American entrepreneurs to coordinating international aviation safety standards.

Third, passage of this amendment would directly threaten ongoing peacekeeping operations in nations essential to American interests. There are now over 115,000 peacekeepers in Darfur, in Liberia, in Haiti, and in the Democratic Republic of Congo. U.N. peacekeeping is eight times less expensive than funding a U.S. force, according to the Government Accountability Office, and these peacekeeping operations help shoulder the burden with our military. U.N. peacekeeping missions also help end brutal conflicts, support stability, the economic development of our allies, and bring relief for hundreds of millions of people. And if not for U.N. peacekeeping missions, some of these conflicts could require the presence of U.S. soldiers.

As a good example, the U.N. peacekeeping force in Haiti has dramatically reduced the number of kidnappings that plague the nation and helped deliver food and medicine, clean streets, and maintain security after several successive tropical storms devastated the country. The mission in Haiti is in the midst of a successful transition from keeping the peace to enhancing security for the people of that country. In the 1990s, Florida faced wave after wave of illegal Haitians trying to escape from the failed state. Should this mission be abandoned? Should we abandon the people of Darfur?

Fourth, the President has stated his commitment to paying U.S. dues to the United Nations and other international organizations that support and advance world peace, security, and economic growth through multilateral organizations. The full payment of assessed contributions affects the standing and influence that the U.S. has at these organizations. Going into arrears undermines U.S. credibility and negatively influences the world opinion regarding the respect and appreciation for the role of multilateral organizations that support and advance U.S. foreign policy.

We all want our veterans and their families to get the best care possible—they have earned it many times over—but this amendment presents us with a false choice between caring for our veterans and protecting our global interests: we must do both. It is for these reasons I oppose Senator Coburn’s amendment and urge fellow Members to oppose the amendment as well.

Mrs. BOXER. Mr. President, I rise in opposition to amendment No. S11537.
2765 to the Caregivers and Veterans Omnibus Health Services Act of 2009.

This is a deeply flawed amendment that may hurt certain veterans of the wars in Iraq and Afghanistan. And for that reason, I must vote against it.

Several disabled veterans often need someone to care for them at home. The family members of these veterans often shoulder the burden of this care, which can take a significant financial, psychological and emotional toll. This bill would provide a family member caregiver with health care, counseling, support and a monthly stipend.

But amendment No. 2765 actually seeks to shut certain Iraq and Afghan- 

stan veterans out of this new benefit by mandating that only those who require “hospitalization, nursing home care, or other residential care” are eligible.

The Wounded Warrior Project characterized the impact of the amendment as such that it would “set a much higher bar” by requiring that the “veteran be so helpless as to require institutional care if personal care were not available.”

This would potentially shut out veterans suffering from severe mental illness, or those learning to adapt to life at home with blindness or amputations.

The Disabled American Veterans also echoed this concern as a reason for opposing the amendment, writing that the amendment’s “new restrictive eligibility language could actually reduce the number of severely wounded and disabled veterans returning home from the wars in Iraq and Afghanistan eligible for such services.”

For these reasons, I urge my colleagues to defeat this amendment, which is also opposed by the American Legion, the Iraq and Afghan- 

stan Veterans of America and Swords to Plow- 

shares.

It is long past time to pass the underly- 

ing bill. This legislation is too im- 

portant to our veterans to sit in Con- 

gress because of the stall tactics of one lone senator.

It includes important health care improvements for women veterans includ- 

ing requiring the Department of Vet- 

erans Affairs to train mental health care specialists on how to better treat military sexual trauma. It also imple- 

ments programs to provide child care to women veterans who require medical care.

In addition, the bill includes two im- 

portant provisions from bipartisan legis- 

lation that I authored with Senator Boxer.

The first gives active duty service- 

members access to vet centers, which are community-based counseling centers run by the Department of Veterans Affairs where veterans can receive mental health care services.

The second provision authorizes vet centers to counsel former servicemem- 

bers on their rights to present their medical records for review to ensure that the discharge process they under- 

went was fair. This is particularly im- 

portant for servicemembers who may have been discharged improperly with a personality disorder and therefore are not entitled to benefits when in fact they actually suffered from a combat-related condition such as post-traumatic stress disorder.

We owe our veterans an enormous 

debt of gratitude, and the best possible treatment and care for injuries sus- 

ained in service to our country. This bill is an important step toward ful- 

filling that obligation.

The PRESIDING OFFICER. The Sen- 

ator from Hawaii.

Mr. AKAKA. Mr. President, can you 

tell me how much time I have remain- 

ing?

The PRESIDING OFFICER. Remain- 

ing on the Senator’s side is 31 minutes 

33 seconds; on the other side, 42 min- 

utes 15 seconds.

Mr. AKAKA. Mr. President, let me 

make further comments about the pending bill on the floor and speak par- 

ticularly about the cost of war.

To those who are concerned about the cost of this legislation, let me say firmly believe we cannot renege on the obligations we have honoredably serve our country. When we as a nation vote to send American troops to war, we are promising to care for them when they return. The cost of veterans health care is a true cost of war and must be treated as such. The cost associated with the underlying bill does not need to be offset. The price has already been paid many times over by the service of the brave men and women who wore our Nation’s uniform.

Regardless of what my colleagues may think about the United Nations and its role in international affairs, this is not the time or place to be de- 

bating those issues. At this moment, we are talking about meeting veterans’ needs.

Iraq and Afghanistan Veterans of America agrees. IAVA writes that:

The amendment to S. 1836 brought to the floor is just the latest in a long series of de- 

laying tactics that plays political games with veterans’ health care and services.

This bill would provide family care- 

givers—who typically have full-time jobs—with health care, counseling, sup- 

port, and a living stipend. This modest stipend would be equal to what a home health agency would pay an employee to provide similar services.

To assert that this legislation re- 

quires excessive spending is simply wrong. This spending is critical when taking into account the sacrifices these men and women have made for the Nation.

The sponsor of the amendment we are considering has expressed the view that S. 1836 unfairly discriminates against veterans because its caregiver assistance provisions focus on OEF and OIF veterans. While it is correct that the caregiver provisions target the vet- 

erans of the current conflicts, I do not believe that constitutes discrimina- 

tion. The reasons for this targeting, at 

the least, are three: one, the needs and circumstances of the newest veterans in terms of the injuries are different— 

different—from those of veterans from earlier eras; two, the family situation of the younger veterans is different from that of older veterans; and three, by targeting this initiative on a spe- 
cific group of veterans, the likelihood of a successful undertaking is en- 

hanced.

I note that most major veterans groups support this bill and the care- 

giver provisions. I do not believe they would do so if they felt it was discrimi- 

natory.

As my colleagues know, I am a vet- 

eron of World War II. If we can provide help to the newest veterans in ways that were not available to the veterans of my generation, I support that 100 percent.

Caregivers from Iraq and Afghanistan are returning home today to face new and different challenges. In World War II, a third of those injured on the battle- 

field did not make it home. Today, 90 percent of those injured make it home but often with catastrophic and life-threatening injuries. Some of these injuries leave invisible wounds. Un- 

precedented rates of post-traumatic stress disorder and other mental ill- 

nesses are affecting these young men and women. These veterans will be cared for somewhere, and by what we do today, we may decide whether that care occurs in a nursing home or in their own home. The soldiers of my generation had no such choice. I say, let’s help the Nation’s newest veterans to really come home, and let’s help their families.

According to a report from the Cen- 

ter for Naval Analyses, 84 percent of caregivers for veterans were either working or in school prior to becoming a caregiver. An employed caregiver will lose, on average, more than $600,000 in wages, pension, and Social Security benefits over a “career” of caregiving. The young veteran’s family, the more wages a caregiver will lose. We can no longer ask our newest generation to bear the cost of the Na- 

tion’s obligation to care for its wound- 

ed warriors.

The premise of the amendment seems to be, if it is good for some, it is good for all. But the needs of veterans are not the same, and expanding a benefit to any veteran who might benefit could endanger the entire program. The un- 

derlying bill already includes a provi- 

sion directing VA to report to Congress within 2 years after the law’s enact- 

ment on the feasibility of expanding the provision of caregiver assistance to family members of prior service. Such an approach is not dis- 

criminatory; it is the responsible way to approach the issue.

I note that other health care im- 

provements—which would result from this bill help virtually every group of veterans, including women veterans, homeless veterans, and veterans who live in rural areas.
November 19, 2009

CONGRESSIONAL RECORD — SENATE

I urge this body to reject the amendment and pass S. 1963 today for the sake of all our Nation’s veterans.

Questions have been raised about the scope of the caregiver provision. When the bill came out of the Veterans’ Affairs Committee, it included a 2-year delay before the caregiver benefit could have been expanded. The bill as reported said the Secretary of VA could have expanded it to all veterans if it made sense. Under the bill now before us, the Congress will continue to have the opportunity to expand it beyond those veterans. Nothing has changed. Once VA has experience with the proposed new program, it can be changed. Once VA has experience with the proposed new program, it can be changed.

The PRESIDING OFFICER. The Senator from Florida is recognized.

Mr. LeMIEUX. Mr. President, 25 years ago—I will never forget this—I came home to my house, I was 15 years old. I was in high school, and my mom and my dad sat me down and my mom told me that she had breast cancer. After that, as any kid would, I worried about whether my mom was going to live and what life would be like without a mom. It was a very difficult time for our family.

The good news is that my mom, through self-examination, found a lump, and she is today, 25 years later, a breast cancer survivor. But I am not sure that today and 25 years ago they told about the positive result that occurred if she had not undertaken that self-exam, if she had not received the care she was given so quickly and so effectively because she found the lump after having been trained and encouraged to do self-exams.

So she is a success story, and millions of women across this country are success stories because they have heeded the advice of preventive medicine. They have chosen to do self-exams and mammograms for women in their forties prevent breast cancer, and they prevent us from losing our moms and our sisters and our daughters. But this week, a task force, a government task force, based on lack of any new information, should contradict its prior recommendation want to do away with self-exams and mammograms on a regular basis for women in their forties. What would be the reason?

The reason is that my colleague from Texas so eloquently stated, is cost. It doesn’t make sense anymore because we are not saving enough lives for the money that it is costing for mammograms. Our moms and our daughters and our sisters are worth that cost.

If you forget the issue of where we are going with this new health care proposal and you want to know what the future is for how the government and your insurance company are going to view your health care, just take a look at what they are looking at. Are they going to say the same thing about men getting prostate exams in their forties? Are we going to start making these cost-based decisions or really furthering them to a degree that we haven’t seen before? Are we going to lose our family members because we are rationing health care? These are big issues.

The American people, as my colleague from Texas said, need to wake up and they need to watch what we do here. My generation is going to happen in this Senate, this great body that debates the important issues. Never has there been an issue as important in modern times as what is going to happen over the next month or 6 or 8 weeks as we discuss these issues that are going to affect our health and our families’ well-being.

I sent a letter to Secretary Sebelius yesterday on this issue. I saw her comments yesterday where she disagrees with this recommendation. Are we making the right decision here for that. Women do not need to get the message now that they shouldn’t be doing self-exams. Women should not be getting the message that they shouldn’t be getting regular mammograms in their forties. They need to do both this because it is going to help save their lives. No government task force, based on lack of any new information, should contradict its prior recommendations that they do just that.

I had a chance to speak with the surgeon general of the State of Florida, Dr. Ana Viamonte-Ros, yesterday about this issue, and she concurs with me, as does the American Cancer Society and other groups, including the American College of Obstetricians and Gynecologists, that women should still do self-exams, and they should still get mammograms on a regular basis in their forties.

I wish to read for this Chamber a letter—e-mail, actually—I received today from a friend of mine down in Broward County from my home State of Florida. She writes:

Please thank the Senator for his efforts on this important issue. I am a breast cancer survivor who was first diagnosed before 50 years of age having a mammogram. Subsequent to the mammogram, my tumor was removed surgically. Unfortunately, within 5 years, I was diagnosed with breast cancer in the other breast and had to undergo surgery and chemotherapy. The second time I found the tumor through self diagnosis. Every day I thank God that I had a life-saving mammogram and that my doctor showed me how to do a self examination.

Just recently I learned through TV that there are also recommendations that women should not utilize self exam as a way to detect breast cancer. It’s too unreliable. More heartbreaking. Most of my sisters found their tumors through self exam. Please ask the Senator to dispel any efforts or notions that self exam is not a good means of detection.

This is an important issue. We need to get the message out to the women of America that these recommendations are wrong. I only can stand here today with this good story about my mom because if she wouldn’t have done that self-exam, she might not be here with us.

So I hope the American people will, as my colleague from Texas said, wake up and see what this means and what it portends for the future.

With that, I yield the floor.

The PRESIDING OFFICER. The Senator from Hawaii is recognized.

Mr. AKAKA. Mr. President, I wish to make further comments on some of the concerns our speakers have had. The amendment sponsor has stated his primary goal is to increase veteran eligibility for caregiver assistance. It appears, however, that the amendment could well have the opposite effect and deny caregiver assistance to many OEF/OIF veterans by significantly narrowing the eligibility criteria for caregiver assistance.

The amendment would add a provision that would require that in addition to sustaining a serious injury and requiring institutional care if personal care services were not available. This proposed modification is problematic because not all veterans in need of caregiver assistance would be so helpless as to require institutional care if personal care services were not available. This provision would have to be so helpless as to require institutional care if personal care services were not available. This proposed modification is problematic because not all veterans in need of caregiver assistance would be so helpless as to require institutional care if personal care services were not available.

To illustrate, consider the example suggested by the Wounded Warrior Project, one of the principal advocates for the caregiver legislation: A veteran who is recovering from severe wounds, suffers from PTSD and depression, and needs help with feeding, dressing, and getting to the bathroom, under the provisions in S. 1963 this veteran would...
be eligible for caregiver assistance. However, since the veteran in this example would not necessarily benefit from or require institutional or residential care, the veteran would not be eligible for caregiver assistance under the changes proposed by the amendment. Given the veteran’s co-occurring PTSD and depression, however, the VA’s failure to provide that assistance could have a severe impact on the veteran’s mental health and well-being. PTSD, one of the signature wounds of the current war, is a condition which many long-term institutional care settings and nursing homes are not prepared to handle or treat. As a result, the inclusion of this new eligibility condition would exclude many veterans in critical need of caregiver assistance.

There is another problem raised by the amendment’s proposed expansion of the caregiver assistance to all veterans. By expanding eligibility for caregiver services to all severely injured veterans, the amendment would convert a manageable initiative targeted on the veterans of the current conflicts into a huge undertaking that would surely encounter many problems.

The reasoning behind initially administering services to a smaller pool allows for greater efficiency and the opportunity to improve before expanding such services to a larger universe of veterans.

I note that the Disabled American Veterans argues against the pending amendment because of its potential impact. DAV writes, and I quote:

While the amendment proposed by Senator Coburn seeks to extend caregiver services to veterans from all eras, its new restrictive eligibility language could actually reduce the number of severely wounded and disabled veterans returning home from the wars in Iraq and Afghanistan eligible for such services. For this and other reasons, DAV does not support the Coburn amendment to S. 1963.

I ask unanimous consent that this letter be printed in the RECORD.

There being no objection, the matter was ordered to be printed in the RECORD, as follows:

### DISABLED AMERICAN VETERANS.

*November 19, 2009.*

**HON. DANIEL K. AKAKA, Chairman, Senate Veterans’ Affairs Committee, Russell Senate Building, Washington, DC.**

**Dear Chairman Akaka:** On behalf of the Disabled American Veterans (DAV), thank you for quickly bringing to the floor S. 1963, “The Caregiver and Veterans Omnibus Health Services Act of 2009.” DAV strongly supports Senate approval of this legislation as introduced, and urges all Senators to support its passage.

S. 1963 combines the content of two prior measures (S. 252 and S. 801) into a single VA health care omnibus bill that would make significant enhancements in VA health care services. This legislation contains vital provisions to help assure equal access to and quality of health care for women veterans. S. 1963 would also provide desperately needed support to family caregivers of severely disabled veterans, particularly those returning from Iraq and Afghanistan, as well as provide mental health services, improve traumatic brain injury care and aid homeless veterans.

As we have shared with you in testimony earlier this year, DAV believes that disabled veterans of all eras could benefit from family caregiver support services. While the amendment proposed by Senator Coburn seeks to extend caregiver services to veterans from all eras, its new restrictive eligibility language could actually reduce the number of severely wounded and disabled veterans returning home from the wars in Iraq and Afghanistan eligible for such services. For this and other reasons, DAV does not support this Coburn amendment to S. 1963.

Mr. Chairman, we look forward to continuing to work with you, Ranking Member Burr, your counterparts in the House and others to craft an expansive and effective caregiver assistance program that we can achieve. Again, thank you for your vigorous leadership on this legislation and for all you have done to support disabled veterans and their loved ones who care for them.

Sincerely,

**JOSEPH A. VIOLANTE,**

National Legislative Director.

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**Mr. AKAKA.** Mr. President, the proponent of this amendment has expressed the view that this veterans omnibus bill should be paid for and seeks to do so by directing a transfer from the State Department to VA of funds appropriated for “Contributions to International Organizations” and “Contributions for International Peacekeeping Activities,” both of which are categories of huge U.S. payments to the United Nations.

Regardless of any Senator’s beliefs about the role of the United Nations or U.S. support for the U.N., this is neither the time nor place to be debating those issues. For that reason alone, I believe the amendment should be rejected.

I understand from CBO, however, this amendment does not even accomplish what I believe the amendment’s author intends. According to CBO, the cost of the bill would still be estimated at the same level. According to CBO, having the State Department transfer funds to the VA is no different than having VA fund it through its own appropriations accounts.

It also appears that the amendment would change nothing with respect to U.S. payments to the U.N. Again, according to CBO, if the amendment’s author wishes to have the State Department transfer funds to VA instead of contributing to the U.N., the amendment would have to be made to the State, Foreign Operations, and Related Programs Appropriations Act, and not to the pending measure which is an authorization bill.

This legislation has been delayed too long. To continue to obstruct this vital veterans bill while attempting to link it completely to unrelated U.N. spending is simply unacceptable.

This amendment should be rejected and S. 1963 should be passed by the Senate.

I yield the floor and reserve the remainder of my time.

**Mr. COBURN.** Mr. President, I listened very carefully to the chairman of the Veterans’ Committee. He misses one major point: If, in fact, we don’t send the money to the U.N., we will have money to pay for the veterans—if we don’t send the money.

That is what this amendment does. It provides a mechanism that money from the State Department’s budget to the U.N. I admit it is fungible, but that is money we will not send to something that is low priority, that is wasteful, that is nontransparent, and that the calls say we think you can agree we get very little value from when we send that money to the U.N.

I also take issue with my friend’s words that it is time. I think the chairman will agree that this bill was not noticed until October 28. That is when this bill was noticed. When the bill was noticed, the next day a unanimous consent request came through to say pass this without any debate, without any discussion, pass it through the Senate. I said, no, we ought to have a debate. At the same time, we have Senator Akaka’s Committee a list of some 20 options of things that are lower priority than helping our veterans. They were rejected out of hand, which is the problem I have been describing on the floor earlier.

Every time it comes down to making a choice, the majority of this body chooses not to make a choice, not to choose a priority, not to do what we get paid to do, not to do what is in the best interests of the Nation. They choose not to not choose. But by choosing not to choose priorities, we still choose, because what we choose is to take the money from our children. We choose to lower the standard of living of our children.

I want to tell you about veterans with whom I have spoken. I have had a lot of calls on this, because how dare somebody hold up a veterans bill before Veterans Day. The vast majority of the calls say we think you ought to support veterans, but we also think you ought to support veterans, but we also think you ought to support veterans, but we also think you ought to support veterans, but we also think you ought to support veterans, but we also think you ought to support veterans, but we also think you ought to support veterans, but we also think you ought to support veterans, but we also think you ought to support veterans.

We have heard three Senators today say there is no price we should not give to support our veterans. Direct quotes: “No price is too great”? There is one price that is too great, because all three of those Senators who spoke today said they would throw away their earmarks to pay for veterans in the VA-MILCON bill. They all voted against paying for it in the MILCON bill by eliminating the unrequested items they had earmarked for them in the VA-MILCON bill. So, yes, there is a price that is too great—the price of helping yourself and your own constituency on a parochial basis and putting that ahead of the best interests for our veterans. So the words “there is no price too great” ring hollow. We put our parochialism in front of the best interests of our veterans.

I ask unanimous consent to add Senators INHOFE and BURR as cosponsors of my amendment.
The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. COBURN. Mr. President, as we talk about this debate, as my colleagues know very well, the debate isn't about veterans; it is not about the veterans; it is not about the rest of the country needing some fiscal sanity in Washington of which we have none. This bill here—the health care bill that was released last night—over the next 10 years will spend $2.5 trillion. That is what it will spend. We don't know the accuracy of CBO. They certainly haven't done very well in the past on health care, as to whether it saves money. What we do know is that it doesn't cut the cost of health care, which is the problem. It transfers $2.5 trillion under the guise of the control of the Federal Government, which is not efficient.

I have not heard one colleague defend the United Nations. Nobody will get up in this body and defend the atrocities, the waste, and the fraud of the U.N. Nobody will say that. But those same people who actually agree with it but won't do anything about it will vote against this amendment. They will vote against the amendment. They won't defend what has very accurately been called the behavior of the lack of fiscal sanity, the fraud and theft, the rape and pillage by the peacekeepers, the lack of oversight, and the total lack of transparency. They are not going to be able to say with words, but they will defend it with their vote. They are going to absolutely defend it with their vote. Once again, they are going to refuse to make the hard choice. Most of them listening to this agree, but it is the wink and nod that we play around this body.

They know the U.N. is a big mess. They know it is a big problem. But they won't do anything to fix it. They will vote for complete transparency and vote to condition our funds on transparency. They get to conference, they will take it out. They will look good on the outside, but the inside of the cup will be absolutely filthy.

When is it we will see a turnaround in Washington that will match the courage of our veterans and meet the expectation of the citizens of this country? When is that going to happen? I will tell you when it is going to happen: It is going to happen when the Chinese start selling our bonds or quit buying bonds when it is not open. Then we are not going to be able to make those decisions based on our choice. They are going to be dictated to us. They are going to be rammed down our throats.

The fact is that $3.7 billion is a lot of money. It is $3.700 million. That is hard to think about when you start talking about billions. Yet we are going to pass it. By the way, this bill that is so critical to get passed right now has no money in it for veterans for this process—so my colleagues agree with that? There is no money there now? It is not going to happen until a year from now, unless we put it in some supplementary program between now and next September 30. So what we are promising isn't going to come due, because we turned down an amendment on the VA-MILCON bill that would have allowed money to be available as soon as possible. The conference committee and the President signs it.

How hollow does that sound? We claim one thing but our actions are totally different. And the VA says, by the way, when they get this bill and the money, it will take at least 180 days to implement it. So add 18 months to right now to when our first veterans will see the benefit, especially the caregivers. And we could have, with the VA-MILCON amendment I offered—which was rejected—made that happen next month—at least the planning in the first 6 months of that—so that by March or April caregivers could actually start receiving this money.

I have tremendous worry for our Nation. If you open your eyes, you will, too, because we cannot keep doing what we are doing.

Just some statistics. These are accurate, based on GAO, OMB, and Congressional Budget Office:

Ending September 30, not counting the supplemental, the Federal Government spent $33,880 for every household in this country. But we only collected an average of $18,000 per family. We borrowed, per family, $15,603 last year. Those numbers are going to be bigger next year. We are going to spend more, we are going to borrow more, and we are going to collect less. What is the implication of that? What is the implication of borrowing money we don't have and spending it on things that are not a priority, such as caring for veterans?
The implication is that it will come to an abrupt halt in a very damaging and painful way—maybe not for us in this body but certainly for my children and my grandchildren, and certainly for those who follow us. There is a part of the financial aspect of it. It is that we are losing, as we do this, the very integral part of what makes our Nation great. It is called "sacrifice." That is why we honor our veterans. It is because they sacrifice, they put themselves on the line. Our heritage has been, from the founding of this country, to the very people who risk their lives and fortunes to initiate this country—the heritage has been of one generation sacrificing for the next so that we have greater opportunity and greater freedom and greater liberty.

As I said earlier, when we come back and get down to the actual voting on this amendment, most people will say: We can't do that. It is not time to make a hard choice.

I want to tell you, those veterans who have closed-head trauma made a hard choice. Those veterans who lost their limbs made a hard choice. Those veterans who lost their eyes made a hard choice. Those veterans who have severe disability and their families made a hard choice.

In a little while, we are going to dishonor that, because we are going to refuse to make a hard choice and rationalize in a way that it isn't going to do any good or make any difference, and we are not going to even attempt to get the out-of-control spending in Washington under control. We will reject the notion that you can, in fact, look at something and see what it is like, such as the waste, such as the rape and pillaging of the U.N. peacekeeping troops, and actually say you can do this. And when we do that, and we are going to refuse to make that sacrifice. It does not honor saying I will make a tough vote, even though the administration doesn't want me to make this vote. I will make this vote because that is right for the country, right for the future, right for our kids and our grandkids. I will make that vote.

We will not see that today. We will not see the courage mustered up to say between what is arguable and a sloppy, ill-run organization into which this country pours billions of dollars every year and continues unabated and uncontrolled and without oversight because we refuse to make a choice.

Just some facts. Here is the choice: Ignore with a blind eye the absolute tragedies that are going on at the United Nations, the absolute waste, the incompetency, the favoritism, the theft that is going on and say you did something good for veterans.

The fact is, the reason our veterans have such severe injuries is because they protect our liberty, protect our freedom, and protect our future. We are not going to choose the opposite. We are going to choose the opposite. We are going to do the status quo. We are going to say this amendment does not make sense.

When will we muster the courage to make a real choice, to go out and defend that veterans are worth more than the waste at the United Nations? We will not make the choice because we know we can vote against this amendment and still tell the veterans we did it. We don't have to say that. We don't have to say that to our grandchildren and children. We will be gone. We will be out of here.

When their standard of living is 35 percent below the standard of living we experience today—by the way, that is what is forecast as the government takes over 40 percent of the GDP of this country and as we end up with interest costs in excess of $1 trillion a year just to fund the excesses of what we are doing today, which is less than 5 years away, and we will be spending $300 billion a year. We will have no recollection of this vote. We will have no recriminations against us. We will have just voted and said that is
another amendment to try to make us make a choice, but we refuse to make one.

By voting against this amendment, you are defending the audacity, corruptness, inefficiency, and fraudulent behavior of the United Nations. That's what you are doing. Nothing can be cut. Have you noticed that? Nothing is not important to the politicians of this city. Everybody has an interest group. Oh, we can't go against that. That is an absolute formula for disaster for our country.

I wish to enter into the RECORD some additional information on the United Nations. I only touched the surface on the amount of outlandish things that have gone on in the United Nations. I did not mention Oil for Food, billions of dollars, and of the people who took all that money, none of them got prosecuted. The U.N. Headquarters renovation is going to cost $2 billion. It should cost about $800 million. I did not talk about that or the lack of transparency in terms of the State Department, in terms of reporting how funds are spent in renovating these facilities that provide at least $293 million in funding for the Department.

I ask unanimous consent to have printed in the RECORD this information.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

**AMENDMENT 2785**

**REDIRECT U.S. DUES TO THE UNITED NATIONS TO THE VETERANS CAREGIVER PROGRAM**

The United States taxpayer is the single largest contributor to the United Nations system that providing over $4 billion annually to the entire United Nations system that is estimated to be at least $30 billion. No one knows for sure how big the U.N. really is—not even the U.N. itself since it operates in an opaque, unaccountable fashion, refusing even the most basic of transparency requests.

The budget that is rife with waste, fraud, and abuse, and the U.N. budget is far worse. Its funding is complicated by diplomatic immunities, spends across international boundaries, but is impossible to audit by U.S. agencies that levy taxes and fees on each other.

This amendment to the Veterans' Caregiver Bill reduces the contributions that the United States makes to the United Nations by a sufficient amount to provide caregiver benefits to ALL severely disabled war-time veterans, not just veterans injured after September 11, 2001. The current bill discriminates against veterans injured prior to that date, as it does not extend the same care that it would provide to individuals after that date.

The national debt just passed $12 trillion and the Congress must pass a debt limit increase. The United States has charged a bill without having the increased spending offset elsewhere is completely irresponsible and further condemning our grandchildren to a lower standard of living.

**UN tainted with fraud, waste, and abuse**

According to internal U.N. reports, U.N. procurement programs suffer from serious fraud and mismanagement problems that taint almost half of the contracts that were audited. The report from the U.N. procurement task force found that 43% of U.N. procurement investigated is tainted by fraud. Out of a budget of $18 billion, this investigation, $630 million were tainted by “significant fraud and corruption schemes.”

The U.N. Environment Program spends over $1 billion annually on global warming initiatives but there is almost no auditing or oversight being conducted. The U.N. Environment Program auditor and one assistant to oversee its operations. According to the task force it would take 17 years for the auditor to oversee just the high-risk areas already identified.

The United Nations Human Settlements program, known as UN-Habitat, only has one auditor, and it would take him 11 years to audit the operations. In the contracts in cases where the U.N. auditors and investigators found evidence of administrative malpractice, the U.N. management has taken no action to examine the managers of the U.N. Department of Economic and Social Affairs abused a $2.5 million trust fund given by the government of Greece. The U.N. auditors recommended that the program repay Greece, but so far, the U.N. has ignored this recommendation.

The U.N. spends annually for its Public Affairs Office, the sole purpose of which is to promote a positive image of the international body. Further, the $1 billion U.N. Foundation is dedicated to pro-U.N. advocacy efforts all over the world.

**United Nations peacekeeping operations**

The U.N. peacekeeping operations plagued by rape and sexual exploitation of refugees—In a draft U.N. report leaked last month detailing how peacekeepers in Morocco, Pakistan, Uruguay, Tunis, South Africa and Nepal were involved in 68 cases of rape, prostitution and pedophilia. The report also stated that the investigation into these cases is being undermined by bribery and witness intimidation by U.N. personnel.

In 2006, it was reported that peacekeepers in Haiti and Liberia were involved in sexual exploitation of refugees. In 2007, leaked reports indicate the U.N. has caught 200 peacekeepers for sex offenses in the past three years ranging from rape to assault on minors. In all of these cases, there is no known evidence of an offending U.N. peacekeeper being prosecuted. Just this month, Human Rights Watch reported that Congolese armed forces, supported by U.N. peacekeepers in the eastern Democratic Republic of Congo have brutally killed hundreds of civilians and committed widespread rape in the past three months in a military operation backed by the United Nations.

Most of the victims were women, children, and the elderly. Some were decapitated. Others were chopped to death by machete, beaten to death with clubs, or shot as they tried to flee.

The U.N. peacekeeping mission provides substantial operational and logistical support to the soldiers, including military firepower, transport, rations, and fuel.

The attacking Congolese soldiers made no distinction between combatants and civilians, shooting many at close range or chopping their victims to death with machetes. In one of the hamlets, Katanga, Congolese army soldiers cut off the heads and limbs 20 meters away from their bodies. The soldiers then raped 16 women and girls, including a 12-year-old girl, later killing four of them.

The U.S. now pays 27% of all U.N. peacekeeping operations. Reducing our contribution to the program will not have any effect on the overall size of the U.N. peacekeeping program, reducing it from $31 billion to $24 billion.

**Oil for Food**

In 1996, the United Nations (UN) Security Council and Iraq began the Oil for Food program to address Iraq's humanitarian situation after sanctions were imposed in 1990. More than $67 billion in oil revenue was obtained through the program, with $31 billion in humanitarian assistance delivered to Iraq.

The U.N. Oil for Food program had weaknesses in the four key internal control standards—risk assessment, control activities, information and communication, and monitoring—that facilitated Iraq's ability to obtain illicit revenues ranging from $7.4 billion to $12.8 billion. In particular, the UN did not provide for timely assessments to address the risks posed by Iraq's control over contracting and the program's expansion from emergency assistance to other areas.

According to GAO, the Oil for Food program was flawed from the outset because it did not have sufficient controls to prevent the Iraqi regime from manipulating the program.

GAO identified over 700 findings in these reports. Most reports focused on U.N. activities in Iraq and the implementation of U.N. Compensation Commission, and the implementation of U.N. inspection contracts.

In the north, OIOS audits found problems with coordination, government, asset management, and cash management. For example, U.N. agencies had purchased diesel generators in an area where diesel fuel was not readily available and constructed a health facility subject to frequent flooding. An audit of U.N.-Habitat found $1.6 million in construction material was not delivered after most projects were completed. OIOS audits of the U.N. Compensation Commission found poor internal controls and recorded millions in U.S. dollars on fraudulent invoices.

**UN headquarters renovation**

In 2008, the United Nations began construction associated with its Capital Master Plan to renovate its headquarters complex in New York City. As the U.N.'s host country and largest contributor, the United States has a vested interest in the way funds are spent in renovating these buildings.

The United Nations headquarters renovation, now estimated to cost $2 billion from the $1.2 billion originally planned, was found to be almost $100 million over its budget before breaking ground on the project.
the cost increase is due to previously hidden “scope options” for “environment friendly” options like planting grass on the roof and electricity-producing wind turbines.

First, the building is expected to adequately maintain its complex after 50 years of deterioration and decay. The U.N. paid millions of dollars to an Italian design firm that had to be fired due to costs. This was followed by three firings of architects, after never producing a single workable plan for the renovation project.

The UN renovation project is just another example of our tax dollars being wasted abroad. The U.N.’s purported $2 billion renovation budget includes over $550 million for expected increased costs and other “contingencies.” The State Department is responsible for at least $485 million in the renovation of the U.N. buildings. However, this figure is likely to rise as GAO has assessed that there exists a high risk that the project will cost much more than anticipated.

Unfortunately, the U.N. renovation program is carried out by the same system responsible for the Oil-for-Food scandal. The U.N.’s own internal audits suggest that the entire procurement system is plagued by corruption.

The current cost of the UN renovation is as follows: $890 million for construction, $350 million budgeted future escalation in costs, $290 million for contingencies, $75 million for redundancies (extra generators, additional fiber optic lines, etc), $40 million “sustainability” (wind turbines, grass on roof, etc). 

UN European “palace” renovation

In addition to housing a massive bureaucracy in New York, the United Nations also keeps a European headquarters, in scenic Geneva, Switzerland. The similarity is striking, as this 70 year old building that used to house nations is reported to need a billion dollars to fully renovate the “Palais de Nations,” as the U.N. building is known, because the building suffers from 70 year old wiring, fire hazards, rusty pipes, asbestos, and a roof caving in.

For cost comparison, $1 billion could build 407,244 square meters of office space in Geneva. That’s one the Oil-for-Food scandal.

Keeping the Palais des Nations could cost more than double what it would take to build a new home from scratch.

The UN’s biggest groups, as said is also larger than the entire humanitarian action appeal for all countries served by UNICEF, the United Nations Children’s Fund, which requested and was able to address $5.4 billion in funding in 2008 for humanitarian emergencies around the world in 2008.

$1 billion could also go a long way to feed the hungry. Oxfam America reports on its Web site that “$1 a week can give 22 families in the Rift Valley of Ethiopia.” and that “$20 buys enough maize to feed a family of four” there for six months—enough food and water to feed millions and flood the valley.

The Director General in Geneva renovated his office this year, though the U.N. would not say how much the changes cost and did not specify whether a member state paid for the work. A spokeswoman said that his office was often overheated by the sun, and he had an air conditioner installed to cool it.

As the United States is responsible for 22% of the U.N.’s budget, it is entirely reasonable to expect that the U.S. taxpayer would be responsible for paying millions of dollars for the renovations of the U.N.’s Geneva offices.

Any major work on the Palais de Nations would likely come after the $1.9 billion renovation of the Empire State Building, and five times more than the $200 million future escalation in costs, $75 million for redundancies (extra generators, additional fiber optic lines, etc), $40 million “sustainability” (wind turbines, grass on roof, etc).

The U.S. taxpayer should not have to pay billions in funding in 2008 and then be refused basic information about that contribution. The Office of Management and Budget and the State Department are willfully ignoring the law regarding congressional reporting requirements for U.N. contributions.

In the National Defense Authorization Act of 2007 and the National Defense Authorization Act of 2010, the Director of the Office of Management and Budget (OMB) is now required by law to report annually to Congress on the total cash contributions to the U.N. from the United States. OMB has passed this responsibility to the State Department, and unfortunately, our lead agency on U.N. issues, the State Department, has not submitted its report for 2008.

Ranking Member Ileana Ros-Lehtinen of House Foreign Affairs Committee comments on the U.N. lobbying for more contributions from the U.S.

“Last year, American taxpayers ponied up nearly $5 billion for the U.N. system. The U.S. is by far the world’s largest donor to the UN. The U.S. pays for peacekeeping operations. The U.S. responds to emergency appeals. We are always on deck. Yet, the head of the UN comes to Congress and scolds us for not doing enough. He demands yet more money from us while making little progress in cleaning up the badly-broken UN.

The U.N.’s ineffectiveness is not from a lack of cash, but the result of a corrupt system which wastes money and apologizes for dictatorships.

The U.N. has been hijacked by a rogues’ gallery that uses our funds to undermine peace and security. Dictatorships use the Human Rights Council and Durban 2 conference process to restrict universal freedoms and protect extremists. The U.N Relief and Works Agency (UNRWA) aid violent Hamas and Al Qaeda. The UN Development Program (UNDP) pays the illegal fees of its corrupt officials but refuses to protect whistleblowers.

While Iran, Syria, and North Korea endanger the entire world, the UN is preoccupied with condemning democratic states like the U.S. and Israel.

Despite these and the dozens of other examples of U.N. mismanagement and fraud, the U.N.’s largest donor, the United States, has not requested any changes to stop the wasting U.S. taxpayer dollars. Instead, the U.N. is receiving even additional amounts of new funding from the U.S. and other donors.

According to the State Department, the U.N. 2008/2009 biennial budget represents the largest increase for a funding request in the U.N.’s history.

The 2008/2009 UN budget is in excess of $5.2 billion. This represents a 25% jump from the 2006/2007 budget that was only $4.17 billion and a 193% increase from the 1998/1999 budget.

The overwhelming majority of the U.N. budget goes to staff salaries and common staff costs including travel to resorts to discuss next year’s budget. The U.N. budget yet and is an estimate that would likely come after the $1.9 billion renovation of the Empire State Building, and five times more than the $200 million future escalation in costs, $75 million for redundancies (extra generators, additional fiber optic lines, etc), $40 million “sustainability” (wind turbines, grass on roof, etc). 

The State Department is willfully ignoring the law and its in reporting transparency on U.S. contributions to the United Nations.

The U.S. taxpayer should not have to pay billions in funding in 2008 and then be refused basic information about that contribution. The Office of Management and Budget and the State Department are willfully ignoring the law regarding congressional reporting requirements for U.N. contributions.

The U.N. has never identified offsets in existing funding in order to pay for new U.N. spending, a position supported by a U.N. General Assembly resolution.

Following the U.N. Secretariat’s poor example, the ¼ of the U.N. not covered by the U.N. budget has experienced massive budget growth due to a complete inability to control spending. Peacekeeping is growing by 40%, the U.N. tribunals by 15% and numerous others by no better than 5%.

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The State Department is willfully ignoring the law and its in reporting transparency on U.S. contributions to the United Nations.
The third thing, regrettably, that they are going to see in that is we are going to continue to play the game the way it has been played: Get the votes to defeat the amendment; we will take a little bit of heat; maybe somebody will notice. I will see you. Twenty years from now, our kids are going to notice, our grandkids are going to notice.

One final thought. If you are under 25 in this country, pay attention to me right now. If you are under 25—there are 70 million of you. Twenty years from now, you and your children will each be responsible for $1,919,000 worth of debt of this country for which you will have gotten no benefit—none. The cost to carry that will be about $70,000. That is not per family, that is per individual. The cost to carry that will be about $70,000 a year before you pay your first tax.

Ask yourself if you think we are doing a good job when we are going to take away your ability to educate your children, when we are going to take away your ability to own a home, and we are going to take away your ability to have that capital formation to create jobs in this country. Watch and see. That number is going to grow every time we do something like this without paying for it, without offsets, without getting rid of something less important.

I yield back the time and yield the remainder of my time to the chairman of the committee.

The PRESIDING OFFICER. The Senator from Hawaii is recognized.

Mr. AKAKA. Mr. President, I wish to make a point of clarification. This bill, the pending measure, is made up of two bills which is now S. 1963. It was S. 252, which was reported in July, and S. 801, which was reported in mid-October. Both bills were held at the time they went into the calendar. No amendment was prepared to either bill. The first amendment was proposed on Monday of this week, 2 weeks after the bills were combined as S. 1963.

In closing, the debate about the United Nations is not one which belongs on a veterans bill. The underlying bill is a bipartisan approach to some of the most urgent issues facing all veterans—for women veterans, for homeless veterans, to help with quality issues, to help rural veterans.

This bill, by the way, also includes construction authorization for six major VA construction projects already funded by the VA spending bill.

I urge our colleagues to reject the amendment to S. 1963.

Mr. AKAKA. I yield back my time. I suggest the absence of a quorum.

The PRESIDING OFFICER (Mr. FRANKEN). The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. LEAHY. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. LEAHY. I thank the Chair.

EXECUTIVE SESSION

NOMINATION OF DAVID F. HAMILTON TO BE UNITED STATES CIRCUIT JUDGE FOR THE SEVENTH CIRCUIT

The PRESIDING OFFICER. Under the previous order, the Senate will proceed to executive session to resume consideration of the following nomination, which the clerk will report.

The bill clerk read the nomination of David F. Hamilton, of Indiana, to be United States Circuit Judge for the Seventh Circuit.

Mr. LEAHY. Mr. President, is there a division of time in this matter?

The PRESIDING OFFICER. The time until 2:30 is equally divided.

Mr. LEAHY. Mr. President, I yield myself 10 minutes.

Mr. LEAHY. Mr. President, the Senate is concluding its long-delayed consideration of the nomination of Judge Hamilton to be Circuit Judge for the Seventh Circuit. Early this week, 70 Senators—Democrats, Independents and Republicans—joined together to overcome a filibuster of this nomination. This has been a record year for filibusters by the Republican minority: filibusters of needed legislation, filibusters of executive nominations and filibusters of judicial nominations, which just a few years ago they proclaimed were “unconstitutional.” Although their filibuster failed, what they achieved was obstruction and delay. This is a nomination that has been stalled on the Senate Executive Calendar for 5 1/2 months, since June 4. In the days since that bipartisan majority of 70 Senators held the debate on the Hamilton nomination, and in the more than 30 hours of possible debate time since then, Republican Senators have devoted barely one hour to the Hamilton nomination. Only four Republican Senators have spoken at all and that includes the Senator from Alabama who repeated the claims he had made five times to the Senate since September 17.

As has been reported since the nomination was made in mid-March, President Obama reached out and consulted with both home State Senators, Senator Lugar and Senator Bayh, a Republican and a Democrat, in making his selection. This stands in sharp contrast to the methods of his predecessor, who was focused on a narrow ideological effort to block the Federal courts, often did not consult, and too often tried to force extreme candidates through the Senate. That is why Republican Senators are now opposing this nomination. Their response to President Obama’s outreach and seeking to turn the page and set a new tone in judicial nominations by restoring comity is to attack his well qualified nominees and stall Senate action. In May, just before Judge Hamilton’s nomination was reported by the committee, a senior Republican Senator reflected upon the Senate confirmation process for judicial nominees and correctly observed: “[C]harges come flying in from right and left that are unsupported and false. It’s very, very difficult for a nominee to push back. So I think we have a high responsibility to base any criticism that we have on a fair and honest statement of the facts and that is what I would not be subjected to distortions of their record.” I agree.

Regrettably, however, that is not how Republican Senators have acted. Judge Andre Davis of Maryland, a distinguished African-American Judge, was stereotyped as “anti-law enforcement” last week by Republican critics, and this week Judge Hamilton, the son of a Methodist minister, is reviled as hostile to Christianity. That is not fair treatment.

The unfair distortions of Judge Hamilton’s record by right-wing special interest groups seeking to vilify him
have been repeated in editorials in the Washington Times and by Republican opponents in the Senate. They resort to twisting and contorting his judicial record and his views, and ignore the record before the Senate. Those distortions of Judge Hamilton’s record were soundly refuted earlier this week by the senior Senator from Indiana, Senator LUGAR. I doubt that I will add to his sound and thoroughgoing rebuttal. Judge Hamilton’s critics are wrong and have been wrong all along. Senator LUGAR and Senator BAYH believe Judge Hamilton is superbly qualified and a mainstream jurist. I agree. Yet Republican critics of Judge Hamilton are determined to ignore the knowledge and endorsement of these home State Senators as well as Judge Hamilton’s long, mainstream record on the bench. They paint an unfair caricature of him. They are wrong to ignore Judge Hamilton’s record of fairly applying the law and how his record and his “willing” rating by the American Bar Association. These critics ignore Judge Hamilton’s testimony before the committee when he said, “I make decisions based on the facts and applicable law of each case. I do not criticize Justice Alito at his confirmation hearing of his perspective. Instead, they concentrate on their end-oriented effort to find him wanting.” Republican Senators did not object when Chief Justice Roberts testified at his confirmation hearing that “of course, we all bring our life experiences to the bench.” Republican Senators did not criticize Justice Alito at his confirmation hearings in 2006 for describing the importance of his background when evaluating discrimination cases. Justice Alito said: “When I get a case about prayer, I have to think about people in my own family who suffered discrimination because of their ethnic background or because of religion or because of gender. And I do take that into account.” I remember one nominee who spoke during his confirmation hearing of his personal struggle to overcome obstacles. He made a point of describing his life as: 

[O]ne that required me to at some point touch on virtually every aspect, every level of our country, from people who couldn’t read and write to people who were extremely literate, from people who had no money to people who were very wealthy. So, when I bring to this Court, I believe, is an understanding and the ability to stand in the shoes of other people across a broad spectrum of this country.

That is the definition of empathy. And that nominee was Clarence Thomas. Indeed, when President George H.W. Bush nominated Justice Thomas to the Supreme Court he touted him as, “a delightful and warm, intelligent person who had a long and distinguished record of evenhandedness on the Supreme Court, explained recently: “You do have to have an understanding of how some rule you make will apply to people in the real world. I think that there should be an awareness of the real-world consequences of the principles of the law you apply.”

Yet now Republican Senators seek to apply a newly constructed “litmus test” that rejects what they had previously viewed as positive attributes as disqualifying. Their opposition to President Alito is virulent that they act as if they must oppose anything he supports. If he sees value in judges with real world perspectives who consider the real impact of various readings of the law on everyday Americans, they must react in knee jerk opposition. They use a distorted lens to review a 15-year judicial record in which he has not substituted empathy for the law to somehow conclude that he will if confirmed to the new appointment. It is reminiscent of the Salem witch trials. They see what they want to see.

Senator LUGAR noted this week that the President of the Indiana Federalist Society endorsed Judge Hamilton as an “excellent jurist and first-rate intellectual” with a judicial philosophy “well within the mainstream.” Senator LUGAR’s own review of his record, with help from a former Reagan counsel, led him to conclude based on that record that “Judge Hamilton has not been a judicial activist and has ruled objectively and within the judicial mainstream.” Senator BAYH reinforced that conclusion with his statements in support of the nomination.

Republican critics are slavishly channeling the talking points of far right narrow special interest groups to twist a handful of the Judge Hamilton’s 8,000 cases to make biased and unfair attacks on the character and record of a moderate judge and a good man. For example, they have misrepresented two of his cases, Hinrichs v. Bosma, 2005, and Grossbaum v. Indianapolis-Marion County Bldg. Authority, 1994, to falsely describe Judge Hamilton, the son of a Methodist minister, as hostile to religion, and to Christianity in particular. In fact, these cases show nothing more than that Judge Hamilton has consistently and objectively performed his duty as a judge to apply the law carefully to the case before him.

In Hinrichs v. Bosma the Judge Hamilton did not eliminate prayer, as some critics have charged. In fact, his narrow and carefully considered ruling was that the Indiana Legislature may begin its sessions with any non-denominational, nonsectarian prayers—prayers that do not advance a particular faith. He noted that those prayers “must be non-sectarian and must not be used to proselytize or advance any one faith or belief or to disparage any other faith or belief.” Prayers that “Christian, Jewish, or from another religion—that advance a particular faith were not permissible.

The plaintiffs in Hinrichs had challenged the Christian orientation of most of the prayers delivered during the 2005 Indiana House session. So, as part of his analysis, Judge Hamilton reviewed the 45 available transcripts of the opening prayers that were offered during that session. He relied on undisputed testimony of scholars and clerics of different faiths who themselves concluded that “many of the legislative prayers delivered during the 2005 House session were sectarian, Christian in orientation, and sent a strong message of non-inclusion to those who are not Christian.” His careful ruling did not depart from settled precedent. It followed the settled law from the Supreme Court and in the Seventh Circuit interpreting the establishment clause of the first amendment of the Constitution.

The critics of Judge Hamilton who have made much of the fact that Judge Hamilton’s decision was overturned by the Seventh Circuit ignore the fact that it was overturned not on the technical issue of establishing the merits of Judge Hamilton’s opinion. In fact, even on this narrow technical point the Seventh Circuit initially upheld Judge Hamilton’s 2006 decision that taxpayers had standing to sue the Indiana House of Representatives, challenging the practice of offering sectarian prayers at the beginning of sessions as a violation of establishment clause. The Seventh Circuit only reversed Judge Hamilton on this technical threshold question after the Supreme Court handed down an intervening 2007 decision, Hein v. Freedom from Religion Foundation, 2007, that was issued after Judge Hamilton’s decision was on appeal. In doing so, the Seventh Circuit acknowledged that it also was reversing its own previous decision in the case that affirmed Judge Hamilton’s ruling that plaintiffs had standing.

These same critics have gone so far as to claim that Judge Hamilton favors Muslim prayers to Christian ones by allowing prayers to Allah, while forbidding prayers to Jesus Christ. This slurred to a Washington Times editorial denouncing the nomination. As Judge Hamilton explained in a ruling on a post-trial motion in Hinrichs, closely following Supreme Court precedent from Employment Division v. Smith, he made use of the word for “God” in another language, such as the “Arabic Allah, the Spanish Dios, the German Gott, the French Dieu, the Swedish Gud, the Greek Theos, the Hebrew Elohim, the Italian Dio” does not make a prayer sectarian, because it does not “advance a particular religion or disparage others.” However, as Judge Hamilton testified in response to a question from Senator GRAHAM, under the reasoning of his ruling in Hinrichs, “a prayer asking that the God of the Prophet would ordinarilly be considered a sectarian Muslim prayer” and impermissible.
Senators who charge that Judge Hamilton’s ruling allows Muslim prayers whole forbidding Christian ones have either not read the case or choose to ignore what it says. Judge Hamilton’s analysis of the 33 opening prayers that were delivered by the Indianapolis Holocaust Memorial Foundation during the 2005 legislative session, found that all but one were delivered by Christian ministers or ministers identified with Christian churches. He noted that the one prayer that was not, which was delivered by a Muslim man, unlike the vast majority of the prayers from Christian clergy, was “inclusive and was not identifiable as distinctly Muslim from its content.”

Judge Hamilton also faithfully applied binding precedent when deciding Grossbaum. In that case, Judge Hamilton correctly relied on then-current Supreme Court and Seventh Circuit precedent interpreting the free speech clause of the first amendment to reach his decision that the Indianapolis building authority acted lawfully in refusing to allow a rabbi to display a menorah in the lobby of the city-county building. His decision relied on a 1990 Seventh Circuit decision, Lubavitch Chabad v. City of Buffalo, which upheld a decision by the city of Chicago to put a Christmas tree in the O’Hare Airport and, at the same time, to exclude private displays of religious symbols.

As with Hinrichs, right wing critics point to the Seventh Circuit’s reversal of Judge Hamilton’s decision to argue that he got it wrong and did not apply the law. What this account leaves out is that the Supreme Court case relied on by the Seventh Circuit to reverse Judge Hamilton did not come down until 1995, after Judge Hamilton issued his decision in Grossbaum. In reversing Judge Hamilton’s decision, the Seventh Circuit clearly noted that Judge Hamilton acted without benefit of the Supreme Court’s new guidance in this area provided by Rosenberger v. Rector & Visitors of the University of Virginia, 1995.

Had Judge Hamilton ignored the binding precedent in certain religion cases to make his decision based on personal beliefs and not the law, he would have been an activist going beyond his role as a district judge. As I read these cases, I had in mind the words of Senator LUGAR who said when he testified in support of Judge Hamilton:

“I have known David since his childhood. His father, Reverend Richard Hamilton, was our family’s pastor at St. Luke’s United Methodist Church in Indianapolis, where his mother was the soloist in the choir. Knowing first-hand his family’s character and commitment to service, it has been my good fortune to me that David’s life has borne witness to the values learned in his youth.

Senator LUGAR knows Judge Hamilton’s character. And the cases critics would use to attempt to show nothing more than that Judge Hamilton is an activist stands, again in Senator LUGAR’s words, “the vitally limited, role of the Federal judiciary faithfully to interpret and apply our laws, rather than seeking to impose their own policy views.”

Critics have similarly twisted and disparaged Judge Hamilton’s record on reproductive rights to paint him as an activist judge. The case at issue is a single case, A Woman’s Choice v. Newman, 1995, even though in that case he carefully applied Supreme Court precedent.

In A Woman’s Choice, Judge Hamilton sided against enforcement of part of an Indiana abortion law that required pregnant women to make two trips to a clinic before having an abortion. Judge Hamilton applied the law set forth by the Supreme Court in Planned Parenthood v. Casey, 1992, and, after carefully examining the facts, concluded that many Indiana women would not be able to make a second trip to a hospital or a clinic. Therefore, under the standard in Casey—the standard that Justice Roberts and Justice Alito pledged to follow as binding precedent when nominees before the Judiciary Committee—Judge Hamilton concluded that the law undermined a woman’s constitutionally protected right to choose.

Critics have seized on a split decision from the Seventh Circuit reversing Judge Hamilton’s decision to grant a pre-enforcement injunction of the informed consent provision to mischaracterize his decisions in that case as activist. However, in reversing Judge Hamilton on the injunction, noted conservative icon Judge Easterbrook was criticized by another judge on the panel for “disregard[ing]” the standards that were established by the Supreme Court in [Casey]” and was criticized for “brush[ing] aside the painstakingly careful findings of fact” that Judge Hamilton made. Even the concurring opinion recognized that Judge Easterbrook’s opinion embraced dissenting opinions in other cases.

Critics have also seized on a falsehood that Judge Hamilton blocked enforcement of the law for seven years, ignoring his modification of the initial injunction to permit Indiana to enforce most of its informed consent law after the Indiana Supreme Court ruled on a State law question of first impression that Judge Hamilton had certified so that he could be guided by the State’s highest court on a question of State law, and ignoring Indiana’s choice not to appeal Judge Hamilton’s timely issued decisions on the injunction until after trial, which Indiana had asked Judge Hamilton to postpone. Judge Hamilton’s decisions in that case show that he was a careful judge showing appropriate deference to Indiana when addressing a matter of first impression in that State, not an ideologue or an activist.

Senators painting a false picture of Judge Hamilton’s record have also cherry-picked his record on the bench of handling criminal cases to focus on one or two cases they assert show that he is too lenient on criminals. Like the other charges against Judge Hamilton, this does not hold up to scrutiny. In his 15 years on the bench, the government has appealed only 2 of the approximately 700 criminal sentences Judge Hamilton has handed down. Judges Hamilton’s critics ignore cases like U.S. v. Turner, 2006, in which Judge Hamilton sentenced a defendant to 70 months imprisonment for possession of counterfeit alien registration receipt cards and for being found in the United States as an alien previously deported after conviction, then denied the defendant’s motion for a reduced sentence. They ignore cases like U.S. v. Garris-Ortega, 2002, in which Judge Hamilton sentenced a defendant to 151 months imprisonment for distributing illegal 60 months on a firearm charge, denying the defendant’s motion for a reduced sentence citing the defendant’s “dangerous role in the distribution network.” They ignore cases like U.S. v. Hagerman, 2007, and U.S. v. Ellis, 2007, in which Judge Hamilton imposed heavy sentences for drug dealing, obstruction of justice, and for tax evasion. This charge against Judge Hamilton simply does not hold up.

Finally, we have heard repeatedly the falsehood that Judge Hamilton is an activist judge who will try to amend the Constitution through the judiciary. However, Judge Hamilton testified in response to written questions from Senators that he believes that “judges do not ‘add’ footnotes to the Constitution and that ‘constitutional decisions must always stay grounded in the Constitution itself.’” In response to Senator SESSIONS, Senator GRASSLEY and others, Judge Hamilton wrote:

The phrase “footnotes to the Constitution” described by my friend, Judge S. Hugh Dillin, refers to the case law interpreting the Constitution. By that phrase, I believe he meant that the general provisions of the Constitution take on their meaning in their application to specific cases, that the case law is not the Constitution itself, and that constitutional decisions must always stay grounded in the Constitution itself. In my view, judges do not “add” footnotes to the Constitution itself. They apply the Constitution to the facts of the particular case and add nothing.

Further, in response to another question from Senator SESSIONS, Judge Hamilton testified: “I have not added footnotes to the Constitution. I believe the constitutional decisions I have made have been consistent with the express language and original intent of the Founding Fathers.” I am hard-pressed to understand why Senators would ask such questions if they do not consider the nominee’s clear answers.

I hope that Senators now considering whether to support the mainstream nominee resist the partisan effort to build a straw man out of one or two opinions in a 15-year record
on the bench. I hope they do not allow right wing talking points to over-shadow Judge Hamilton’s long and distingushed record on the bench. Instead, I urge Senators to heed the advice of Senator Lugar who urged that “confirmation decisions should not be based on general considerations, much less on how we hope or predict a given judicial nominee will ‘vote’ on particular issues of public moment or controversy.”

This is a nomination that should be confirmed and should have been confirmed months ago. David Hamilton is a fine judge and will make a good addition to the United States Court of Appeals for the Seventh Circuit.

Mr. President, I ask unanimous consent to have a copy of the Washington Post article to which I referred printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD as follows:

[From the Washington Post, Nov. 19, 2009]

**The GOP’s No-Exit Strategy**

(By E.J. Dionne, Jr.)

Normal human beings—let’s call them real Americans—cannot understand why 10 months after President Obama’s inauguration, we find ourselves tied down in a procedural tortoise race. Hamilton's case is just the one instance that help to vet judges, is snarled—guess where?—in the Senate. Republicans are using the filibuster to stall action even on bills that most of them support. Remember: The rule is to keep Democrats from the exit.

As of last Monday, the Senate majority had filed 58 cloture motions requiring 32 recorded votes. One of the more outrageous cases involved an extension in unemployment benefits, a no-brainer in light of the dismal economy. The bill ultimately cleared the Senate this month by 96 to 0. The vote came only after the Republicans launched three filibusters against the bill and tried to lard it with unrelated amendments, delaying passage by nearly a month. And you wonder why it’s so hard to pass health care?

Defenders of the Senate always say the Founders envisioned it as a deliberative body that forces compromise. The Senate is that place.

But Sessions unintentionally blew the whistle on what’s happening now with nothing to do with the Founders’ design. The rules have changed. The extra-constitutional filibuster is being used by the minority, with extraordinary success, to make the majority look foolish, ineffectual and incompetent. By using Republican obstructionism as a vehicle for forcing through their own narrow agendas, supposedly moderate Republicans will only make themselves complicit in this humiliation.

The PRESIDING OFFICER. The Senator from Alabama is recognized.

Mr. SESSIONS. Mr. President, we moved three judges through committee today, and I think, all in all, Senator LEAHY is working us to death. But we are making some progress.

I would note for the record, if anybody would like to know, there are 21 circuit vacancies for circuit courts in America. The President has nominated 63 people for those openings. There are 76 district court vacancies, and as of November 16 the President has nominated 10. He has more vacancies than President Bush had at this time and he has nominated fewer people. But a lot of the things keep happening: They will catch up. You can have a paid chaplain who com-municate the beliefs that Jesus of Nazareth was the Christ, the Messiah, the Son of God, or the Saviour, or that he was resurrected, or that he was the Christ, the Messiah, the Son of God, or the Saviour, or that he was resurrected, or that he was...
Judge Hamilton skip over the very basic preliminary legal issue of standing and instead move directly to the merits of the case, if the standing didn’t exist? I submit he perhaps desired to rule on the merits because he favored the outcome he produced.

In A Woman’s Choice v. Newman, Judge Hamilton succeeded in blocking the enforcement of a reasonable informed consent law for 7 years, an Indiana law. In 1995, the Indiana Legislature passed a statute that required certain medical information to be provided to women seeking an abortion at least 18 hours prior to the procedure. The Supreme Court, in Planned Parenthood v. Casey, a very important case, had already held very similar requirements were constitutional and did not restrict the right to an abortion. It just required that the information provided to you 18 hours in advance. Notwithstanding the Supreme Court precedent, Judge Hamilton granted a preliminary injunction against the enforcement of the law. In other words, he stopped the law from going into effect. He assumed the role of a legislator. He took out his judicial pen and struck some of the language from the statute, language he didn’t like.

The statute required that women receive this information in person, not through some third person. Judge Hamilton modified the injunction so as to prevent the State from enforcing the requirement that the information be provided “in the presence of” the pregnant woman. He later entered a permanent injunction that prohibited enforcement of the law, in essence vetoing the law. Finally, the case reached the Seventh Circuit. In an opinion by Judge Easterbrook, the court reversed, concluding that Judge Hamilton had abused his discretion. A Federal judge with a lifetime appointment has power over what he says the Constitution is violated by what a State does, the judge has the power to invalidate what the State does. But this is an awesome power and ought to be used carefully. When this case reached the Seventh Circuit, this is what the opinion said:

[For 7 years, Indiana has been prevented from enforcing a statute materially identical to a law held valid by the Supreme Court in Casey, by this court in Karlin, and by the Fifth Circuit in Barnes. No court anywhere in the country (other than one district judge in Indiana) has held any similar law invalid in the years since Casey v. Indiana (like Pennsylvania and Wisconsin) is entitled to put its law into effect and have that law judged by its own consequences.

If it is a bad law, the people would change it. They have the power to do so.

I suggest that it is a pretty stark criticism and a very serious one. One single judge has frustrated a law that was constitutional for 7 years.

In U.S. v. Woolsey, Judge Hamilton disregarded a defendant’s prior conviction for a felony drug offense in order to avoid imposing a mandatory sentence of life imprisonment for persons convicted of a third felony drug offense. Here the defendant was convicted of drug and firearms offenses after police executed a search warrant at his home where they discovered a half pound of cocaine, 31 pounds of marijuana, 2 bags of methamphetamine—and that is a lot of methamphetamine—a cache of guns, and $16,000 in currency. Because the defendant had two prior felony drug convictions, the defendant was subject to a life sentence for the weapons.

Judge Hamilton was reversed because he ignored one of those prior convictions, reversed unanimously by the circuit court on which he now wants to sit.

This is what they said about his willfulness:

[We have admonished district courts that the statutory penalties for recidivism . . . are not optional, even if the court deemed them unwise or an inappropriate response to repeat drug offenders.

They were saying: Judge, you have been letting your personal views override what you are required to do by the law. You are a judge. You are supposed to follow the law. The oath you take is to follow the Constitution and the laws of the United States. You are not above it.

The opinion makes clear that Judge Hamilton either made several unnecessary errors or intentionally ignored the law.

In Grossbaum v. Indianapolis-Marion County Building Authority, Judge Hamilton denied a request by a rabbi to place a menorah in a county building. A unanimous panel of the Seventh Circuit reversed Judge Hamilton’s ruling, noting that two Supreme Court cases were directly on point.

For 8 years the plaintiff in this case had been able to display a menorah during Chanukah until the ACLU challenged the display as violating the First Amendment. Because of the ACLU’s challenge in 1993, Marion County unanimously adopted a “policy on seasonal displays.” They set up a policy to try to make everybody happy. It was done to try to keep the courts happy by preventing a menorah from being displayed.

In 1994, when the plaintiffs submitted a request to display the menorah, they were denied.

Mr. President, I know my time is up, and I ask unanimous consent for 1 additional minute.

Mr. LEAHY. Provided there is another minute on this side.

Mr. SESSIONS, I understand. The PRESSING OFFICER, Without objection, it is so ordered.

Mr. SESSIONS. Mr. President, there are other matters that I don’t have time to go into in detail. Any nominee is entitled to a fair hearing. They ought not have their record distorted. At the Senator said, we can make mistakes sometimes. But I think the pattern is such that it indicates to me there are extraordinary circumstances that justify an objection to the nomination because the nominee has shown a willfulness to override the law. A judge must be under the law.

I offer the following more detailed explanation to try to go into even more detail and to fairly analyze the judge’s record and why I think they are unacceptable.

There have been some accusations that we have mischaracterized Judge Hamilton’s record, and, specifically, some of his cases. I would like to take each of those cases and explain why I am concerned about Judge Hamilton’s judicial philosophy and demonstrate how we have not mischaracterized his rulings.

In Hinrichs v. Bosma, 400 F. Supp. 2d 1103, S.D. Ind. 2005, the Indiana ACLU, representing some taxpayers, brought suit against the Speaker of the Indiana House of Representatives claiming that “most” of the prayers that opened legislative sessions were sectarian Christian prayers in violation of the first amendment. Although 29 out of 45 of the prayers for which there were transcripts were Christian, many prayers were offered by state legislators, a rabbi, and a Muslim imam.

Nevertheless, Judge Hamilton enjoined the speaker from allowing sectarian prayers because some of them mentioned Jesus Christ and therefore might “advance a particular religion, contrary to the mandate of the Establishment Clause.” Judge Hamilton also ordered the speaker to advise any officiant that a prayer must be nonsectarian, must not advance any one faith or disparage another, and must not use “Christ’s name or title or any other denominational appeal.”

In so holding, Judge Hamilton relied on what I think is a flawed reading of the Supreme Court’s decision in Marsh v. Chambers, 463 U.S. 783, 1983, which held that a legislative body may open its session with a prayer, much like we do in the Senate. Judge Hamilton said that the Marsh case did not expressly permit prayers that were “explicitly Christian or explicitly Jewish.” But the Supreme Court in Marsh said:

The content of the prayer is not of concern to judges where . . . there is no indication that the prayer opportunity has been exploited to proselytize or advance any one, or to disparage any other, faith or belief. That being so, it is not for us to embark on a sensitive evaluation or to parse the content of a particular prayer.

Judge Hamilton ignored the Supreme Court’s clear directive that the content of such prayers should not be of concern to judges. He had concerns about whether he would parse through the content by dictating from the bench what constitutes sectarian prayer. In fact, in a later ruling denying the speaker’s request to stay the permanent injunction, Judge Hamilton came close to doing so when he said the speakers’ prayers in the name of Jesus Christ would be sectarian and therefore prohibited, but prayers in the name of Allah would not
be sectarian and therefore allowed. He said:

Prayers are sectarian in the Christian tradition when they proclaim or otherwise communicate the beliefs that Jesus of Nazareth was the Christ, the Messiah, the Son of God, or the Savior, or that he was resurrected, or that he will return on Judgment Day or is otherwise divine. . . .

He went on to say:

If those offering prayers in the Indiana House of Representatives choose to use the Arabic Allah . . . the court sees little risk that the choice of language would advance a particular religion or disparage others.

I find it hard to believe that anyone would not associate a reference to Allah with Islam.

After full briefing and oral argument, the Seventh Circuit reversed Judge Hamilton’s decision, finding that the taxpayers lacked standing to bring the lawsuit in the first place. The court of appeals did not reach the merits of the case, but the question naturally arises: Why did Judge Hamilton skip over the very basic, preliminary issue of standing and instead move directly to the merits of this case? I submit that Judge Hamilton wanted to get to the merits of the case he sought this particular outcome.

In A Woman’s Choice v. Newman, 994 F. Supp. 1434, S.D. Ind. 1995, Judge Hamilton succeeded in blocking the enforcement of a reasonable informed consent law for years. In 1995, the Indiana legislature enacted a statute that required women seeking an abortion to receive certain medical information at least 18 hours prior to the abortion being performed. Specifically, the statute required that the women be informed of the following information:

1. The name of the physician performing the abortion.
2. The nature of the proposed procedure or treatment.
3. The risks of and alternatives to the proposed procedure or treatment.
4. The probable gestational age of the fetus.
5. The medical risks associated with carrying the fetus to term.
6. The availability of fetal ultrasound imaging.
7. That medical assistance benefits may be available for prenatal care . . . from the county office of the division of family resources.
8. That the father of the unborn fetus is legally required to assist in the support of the child.
9. That adoption alternatives are available and that adoptive parents may legally pay the costs of prenatal care, childbirth, and neonatal care.

The Supreme Court in Planned Parenthood v. Casey, 505 U.S. 833, 1992, had already held that very similar requirements did not restrict the access to abortions and that is an important point here.

Despite the Casey decision, and an almost identical Seventh Circuit opinion upholding a Wisconsin statute, the plaintiffs filed a lawsuit challenging the constitutionality of the Indiana law on the grounds that it was likely to impose an undue burden on a woman’s right to choose. I am not sure how knowing the name of the doctor who is performing an abortion imposes an undue burden. In support of their argument, the plaintiffs presented evidence that the law is likely to prevent abortions for approximately 11 to 14 percent of women who would otherwise choose to have them and the “medical emergency” exception would probably fail to meet constitutional standards as unduly narrow.

Judge Hamilton granted the plaintiffs a preliminary injunction with certified questions to the Supreme Court of Indiana concerning the interpretation of the “medical emergency” exception under State law.

The Indiana Supreme Court answered the certified questions and basically held that Indiana’s law did not violate the Supreme Court holding in Casey.

The Supreme Court held that Indiana’s law did not violate the Supreme Court holding in Casey. The Indiana Supreme Court concluded:

The medical emergency provision of Public Law 6-187 is not in conflict with the informed consent requirements when the attending physician, in the exercise of her clinical judgment in light of all factors relevant to a particular case, concludes in good-faith that medical complications in her patient’s pregnancy indicate the necessity of treatment by therapeutic abortion. We add that the physician may do so with respect to serious and permanent mental health issues. A physician may not, however, dispense with the informed consent provisions as to health problems when they are temporary.

This holding by the Indiana Supreme Court should have resolved the matter.

Notwithstanding, Judge Hamilton assumed the role of a legislator, took out his judicial pen and struck some language from the Indiana statute. The statute required that women receive this information in person. Judge Hamilton modified the preliminary injunction that he had issued so as to prevent the State from enforcing the requirement that the information be provided “in the presence” of the pregnant woman. Judge Hamilton later entered a permanent injunction that prohibited enforcement of the law—in essence vetoing the law.

Finally, the case reached the Seventh Circuit, which reversed Judge Hamilton’s ruling. In a 2-1 opinion by Judge Easterbrook, the court concluded that Judge Hamilton abused his discretion:

For seven years Indiana has been prevented from enforcing a statute materially identical to the one held valid by the Supreme Court in Casey, by this court in Karlin, and by the fifth circuit in Barnes. No court anywhere in the country (other than one district judge in Indiana) has held any similar law invalid in the years since Casey . . . . Indiana (like Pennsylvania and Wisconsin) is entitled to put its law into effect and have that law enforced by the courts.

In a concurring opinion, Judge Coffen concluded:

Judge Hamilton’s opinion which was pronounced without the support of even one citation to the record, invades the legitimate province of the lower courts and places a straitjacket upon their power to regulate and control abortion prac-

tice. As a result, literally thousands of Indiana women have undergone abortions since 1995 without having had the benefit of receiving the necessary information to ensure that they can make an informed choice. . . . Judge Hamilton’s decision questioning the wealth of information available to make a well-informed and educated life-or-death decision . . . . Judge Hamilton abused his discretion when depriving the sovereign State of Indiana of its lawful right to enforce the statute before us. I can only hope that the number of women in Indiana who may have been harmed by the judge’s decision is but few in number.

Three different courts, including the Indiana Supreme Court, had looked at Indiana’s statute and laws and concluded they passed constitutional muster. This apparently did not satisfy Judge Hamilton and so he ignored the precedent and ruled based on his own policy preferences.

In United States v. Woolsey, 535 F.3d 540 (7th Cir. 2008), Judge Hamilton disregarded a defendant’s prior conviction for a felony drug offense in order to avoid imposing a mandatory sentence on the defendant who was convicted of a third felony drug offense. Judge Hamilton was reversed by a unanimous Seventh Circuit:

[We have admonished district courts that the statutory penalties for recidivism . . . are not optional, even if the court determines them unwise or an inappropriate response to repeat drug offenders.

Here, the defendant was convicted of drug and firearms offenses after police executed a search warrant at his home, where they discovered a half pound of cocaine, 31 pounds of marijuana, 2 pounds of methamphetamine, a cache of guns and $16,000 in currency. Because the defendant had two prior felony drug convictions in 1997 and 1974, the defendant was subject to recidivism penalties under Federal statute.

At sentencing, the government properly filed an enhancement information detailing the two prior convictions, which should have triggered a mandatory term of life imprisonment. Although the defendant conceded that his 1997 drug conviction would count for enhancement purposes, he contested the eligibility of the 1974 conviction. The defendant argued that he believed the 1974 conviction—possession with intent to distribute 125 pounds of marijuana—should have been set aside upon successful completion of his probation pursuant to the Federal Youth Corrections Act. The Federal Youth Corrections Act allows previous sentences to be set aside in cases where there was previously an improperly charged enhancement and where the probationer had “demonstrate[d] good behavior to the sentencing court before the probationary period ended.”

Here, the Arizona district court that had sentenced the defendant did not grant the early discharge. The defendant claimed this was an oversight, so Judge Hamilton postponed the defendant’s sentencing to give him a chance to petition the Arizona court. The 1974 conviction cleared. According to the opinion reversing Judge Hamilton, “the Arizona court was not inclined to grant the request.” We know
the defendant had another conviction beyond 1974, so perhaps he did not meet the good behavior requirement.

The Seventh Circuit also noted that the Federal statute: bans any challenge to the validity of any prior conviction alleged under this section which occurred more than five years before the date of the information alleging such prior conviction . . . . [The defendant] never denied the conviction, and the five-year window closed some time ago.

At sentencing, Judge Hamilton chose to disregard the 1974 conviction and not impose a life sentence. He stated: I believe that the circumstances to not count the 1974 marijuana conviction for this purpose. On that issue, with respect to both the guidelines and the [federal statute], I will say that it seems to me that there is no apparent reason in this record why the defendant should not have been discharged early as to what is the customary practice as was intended and, in essence, the Court ought to treat as having been done what should have been done under general equitable powers.

The Seventh Circuit vacated the sentence and remanded Judge Hamilton: ‘‘[t]he Indiana district court was not free to ignore Woolsey’s earlier conviction . . . . as Tuten makes clear, the court that imposed a sentence under the TCA should be the one to exercise the discretion afforded by the Act.’’

The court further stated: sentencing is not the right time to collaterally attack a prior conviction unless the prior conviction was obtained in violation of the rules which (the defendant) does not suggest. . . . Accordingly, the decision to disregard [the defendant’s] prior conviction in light of what the court believed ‘‘should have been done’’ three decades earlier was incorrect.

I think this opinion makes it clear that Judge Hamilton either made several unnecessary errors in his ruling or intentionally ignored the rule of law because he did not like the sentence. I believe it was the latter of the two.

In Grossbaum v. Indianapolis-Marion County Building Authority, 870 F. Supp. 1459 (S.D. Ind. 1994), Judge Hamilton denied a rabbi’s request to display the menorah from being displayed. So in 1994 when the plaintiffs submitted a request to display the menorah, their request was denied by filing a motion for a preliminary injunction to require the county building manager to allow them to display a menorah in the non-public forum lobby of the building, something they had intended to do every holiday season between 1985 and 1992.

Judge Hamilton denied the motion, stating that the First Amendment’s free speech clause did not require Marion County to allow the display and that the county was reasonable in believing the establishment clause prohibited it from doing so. He refused to apply controlling Supreme Court precedent and instead embraced what appears to be an evolving standard based on something other than the law. He said: ‘‘[o]ne of the challenges . . . is to keep the structure of abstract analytic categories and logical tests in touch with the practical realities before the court.’’

Judge Hamilton also ruled that Marion County’s policy was a permissible ‘‘subject matter restriction’’ under the first amendment, rather than prohibiting ‘‘viewpoint discrimination.’’ Specifically, he decided that the county could put up its own ‘secular holiday symbol,’’ a Christmas tree, while excluding anyone from expressing a religious view of the holiday season. He then concluded that the county could choose to allow symbols that might be provoked by the display of religious symbols and that ‘‘practical considerations’’ justified his reading of the Constitution. Indeed, Judge Hamilton stated that the plaintiff’s position could not be sustained, because, if it were, the result would be that ‘‘every time a government [put] up a Christmas tree (or perhaps a wreath or some other green branches) in a ‘nonpublic forum,’’ that government would have to extend an invitation to all interested private parties to display the religious symbols of their choice in the same area. As a practical matter, that result would be dramatic.’’

In an opinion by Judge Ripple, the Seventh Circuit unanimously reversed. The court rejected Judge Hamilton’s attempts to distinguish the case from the Supreme Court’s decisions in Rosenberger and Lamb’s Chapel, holding that the government made the menorah’s message because of its religious perspective was unconstitutional viewpoint discrimination. The court found that the county’s policy: ‘‘clearly concerns ‘seasonal displays’ in its ‘government imposed’ . . . . clearly is a prohibition of one type of seasonal display, namely religious displays and symbols.’’

The Seventh Circuit also said: the court’s colleguey with counsel at oral argument made it quite clear that the policy challenged here was to prevent one thing: seasonal holiday displays of a religious character.

Because neutrality and equal access to the nonpublic forum lobby avoided establishment clause problems, the Seventh Circuit held the county’s establishment clause defense was insufficient.

The Seventh Circuit saw very clearly what Judge Hamilton seems to have been far too distracted by ‘‘practical realities’’ to realize—that the government policy in question was based solely on the viewpoint expressed and, thus, unlawful. Judge Hamilton, by all accounts, has a talented legal mind. Therefore, I can only conclude that the ‘‘practical reality’’ Judge Hamilton was so concerned with was, in fact, the result he wanted to reach.

Finally, in United States v. Rinehart, 2007 U.S. Dist. LEXIS 14948, S.D. Ind. February 2, 2007, the defendant, a police officer who filmed himself having sexual relations with a minor, pled guilty to two counts of producing child pornography. Although Judge Hamilton sentenced him to the mandatory minimum of 15 years in prison, he took the highly unusual step of issuing a written opinion ‘‘so that it may be of assistance in the event of an application for executive clemency,’’ an action that Judge Hamilton called ‘‘appropriate.’’

The defendant, a 32-year-old cop, engaged in ‘‘consensual’’ sexual relations with two young girls, ages 16 and 17. According to Judge Hamilton’s opinion, the sexual relationships were legal under State and Federal law. However, the defendant took photos and videos of himself and the girls engaged in ‘‘cursory’’ sexual conduct and also showed them ‘‘how to execute the same conduct’’ on his home computer and he was charged under the Child Protection Act of 1984.

In his written opinion, Judge Hamilton noted his disagreement of the mandatory minimum and concluded: I would impose a sentence of not more than 15 years in prison, I would suggest Judge Hamilton could and did legally consent to the sexual relationships. The defendant took photos and videos of himself and the girls engaged in sexual relations. These images were found on his home computer and he was charged under the Child Protection Act of 1984.

In this case, involving sexual activity with victims who were 16 and 17 years old and who could and did legally consent to the sexual activity, Judge Hamilton’s punishment could be modified to become just is through an exercise of executive clemency by the President. The court hopes that will happen.

That last sentence embodies precisely the type of activist philosophy that I have been talking about. But here, we do not need to read between the lines. We do not need to infer a thing. Judge Hamilton laid it on in an opinion. And the opinion had the express aim of urging the executive to adopt his policy preferences. When a judge steps outside of his constitutional role of interpreting and applying the law as written, he undermines the entire justice system.

These are just a few of the problematic cases in Judge Hamilton’s record. To date, the Seventh Circuit has been able to reverse these errors, but if he is elevated, only the Supreme Court will be able to reverse most of his errors. I am afraid the Supreme Court might not hear some of them. This body should elevate those judges who have performed admirably during lower court service, not those who have performed poorly.

I yield the floor.

Mr. CORNYN. Mr. President, I will not support Judge David Hamilton’s elevation to the Court of Appeals for the Seventh Circuit. After close review, I believe Judge Hamilton’s writings on
Mr. LEAHY. Mr. President, as I sit here and listen, I wonder who in Heaven’s name they are talking about. Judge Hamilton had 8,000 cases. Apparently, there is no problem with any of them except for a tiny handful of cases, and those have been so distorted by Judge Hamilton’s comments that I don’t even understand them. Basically, I think they are saying what he should have done is gone by his personal beliefs and not the law. Of course, then they could say he was an activist judge.

He is in a situation where they will try and get him either way. A judge can follow the law, do what they are supposed to do, try 8,000 cases, get strong support from people from the right to the left, and get the highest possible rating a judge can get. But don’t worry. We are going to take some case or two out of context from their 15 years on the bench. We will ignore 8,000 cases. We will call them a gender-driv-en ideology. We will point to a single case, even though in that case they carefully applied Supreme Court precedent.

Come on. Let’s be fair. Eight thousand cases, the highest rating possible, endorsed by everybody who knows him, and strongly backed by Senators LUGAR and BAYH. Judge Hamilton is not an ideologue. Apparently, there is no problem with any of his 8,000 cases except a couple that people have taken out of context and twisted to be an ideological science of the Nation. We are above that, and we should vote for his confirmation.

AMENDMENT NO. 2785

Mr. President, I also want to take a couple of minutes to speak against Senator COBURN’s amendment to the veterans health bill we will be voting on shortly.

Senator AKAKA has already explained that we do not need the Coburn amendment to fund keeping missions and who funds are used for by the United Nations. Just funding for the United Nations to care for our veterans. That is a false choice.

This is nothing more than a ploy to take a swipe at the United Nations. Senator COBURN spoke earlier, and his statement consisted of a laundry list of factual inaccuracies about the United Nations.

Is the United Nations perfect? Far from it. Truth be told, one thing. Inventing facts is another. To say that the U.N. Development Program provided millions of dollars to North Korea which used the funds to manufacture ballistic missiles, when there is no proof of that, does not belong in this debate. I would say to those Senators who think the United States should not fulfill its treaty obligations to the United Nations, who think we should renege on our commitments to support U.N. peacekeeping missions and who want walking away from our pledges to NATO, the International Atomic Energy Agency, the World Health Organization, and many other organizations we were instrumental in creating, then vote for this misguided amendment.

But if Senators believe that United States leadership in the world means paying our share and being able to use our influence, then I urge Senators to oppose this amendment.

Our assessed contributions to the United Nations, which the Coburn amendment would cut, support a wide range of activities that advance our own national interests. That was true during the Bush Administration, which would have opposed this amendment, as it is today. The State Department opposes this amendment.

Here are some examples of what the funds are used for by the United Nations and other international organizations that Senator COBURN’s amendment would cut:

Preparing for and holding elections in Iraq

Monitoring nuclear programs in North Korea and Iran. Do we really want to cut funding for the international nuclear inspectors who Iran finally allowed into one of their facilities?

Supporting NATO. I can’t imagine any Senator wants to cut our contribution to NATO, when we are asking our NATO allies to do more in Afghanistan.

Funding 17 U.N. peacekeeping missions, including in Haiti, Liberia, Lebanon, Darfur and the Congo. We don’t contribute troops for these missions, but we pay for them.

Supporting the Food and Agriculture Organization’s forecasts of global food production, identifying areas of drought and famine, to provide emergency food assistance.

Coordinating tsunami and earthquake relief in Indonesia and Pakistan. Coordinating international aviation safety standards.

Coordinating efforts by the global shipping industry and governments to respond to acts of piracy on the high seas.

These are organizations that are advancing our own interests.

President Obama has stated his commitment that the U.S. will pay its dues to U.N. peacekeeping and international organizations. The Appropriations Committee has acted on that commitment. We are once again in good financial standing at the United Nations. This amendment would put us back in arrears.

Our dues to the United Nations and other international organizations are treaty obligations. Not paying is not an option.
The result was announced—yeas 59, nays 39, as follows:

YEAS—59

Akaka  Hagan  Murray
Bayh  Harkin  Nelson (ND)
Begich  Inouye  Nelson (FL)
Benetti  Johnson  Pryor
Bingaman  Kaufman  Reed
Boxer  Kerry  Reid
Brown  Kirk  Rockefeller
Burr  Kobuchar  Sanders
Cassell  Kohl  Schumer
Cardin  Landrieu  Shaheen
Casey  Lautenberg  Specter
Conrad  Levin  Stabenow
Dodd  Lieberman  Tester
Durbin  Lugar  Udall (CO)
Feingold  McCaskill  Udall (NM)
Feinstein  Menendez  Warner
Franken  Merkley  Webb
Gibilisco  Mikulski  Wyden

NAYS—39

Alexander  Capito  LeMieux
Barrasso  DeMint  McCain
Bennett  Ensign  McConnell
Bond  Enzi  Murkowski
Brownback  Graham  Risch
Bunning  Grassley  Roberts
Burr  Gregg  Sessions
Chambliss  Hatch  Shelby
Cochran  Hutchison  Snowe
Collins  Inhofe  Thune
Corker  Isakson  Vitter
Corryn  Johanns  Voinovich
Wyden

NOT VOTING—2

Baucus  Byrd

The nomination was confirmed. The PRESIDING OFFICER. The President will be immediately notified of the Senate’s action.

LEGISLATIVE SESSION

The PRESIDING OFFICER. The Senate will resume legislative session.

CAREGIVERS AND VETERANS OMNIBUS HEALTH SERVICES ACT OF 2009—Continued

AMENDMENT NO. 2785

The PRESIDING OFFICER. There will now be 2 minutes of debate equally divided on the amendment offered by the Senator from Oklahoma, Mr. COBURN.

The Senator from Oklahoma is recognized.

Mr. COBURN. This is a straightforward amendment. You get to decide whether you want to continue to send money to an organization that is bankrupt; or you have peacekeeping troops that rape men, women, and children; has absolutely no transparency in spite of our law that demands it, or to pay for the courage and the support of people who do deserve it.

We always have a reason not to make the hard choice. I suspect we will find a good reason not to make the hard choice this time. But for $3.7 billion to help the people who help us and quit sending money that goes down the tube—half of everything we send to the United Nations gets wasted or defrauded—it is time for us to make the hard choice. That is what the amendment is about. There are a lot of reasons you can find to vote against it. It will take real courage to vote for it.

The PRESIDING OFFICER. The Senator from Hawaii is recognized.

Mr. AKAKA. Mr. President, I urge our colleagues to reject the pending amendment. For one thing, it appears that the amendment could end up defunding caregiver assistance to many OEF/OIF veterans by significantly narrowing the eligibility criteria for caregiver assistance. While the amendment seeks to “pay for” the costs associated with this bill, I understand from CBO, however, that this amendment does not even accomplish what I believe the amendment’s author intends.

Every major veterans group supports the underlying bill because of what it means for all veterans—for women veterans, for homeless veterans, and for veterans of every era.

I urge a “no” vote on the amendment, followed by a vote to pass S. 1963.

The PRESIDING OFFICER. All time has expired.

The question is on agreeing to the amendment. Mr. LeMIEUX. I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second? There is a sufficient second.

The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. DURBIN. I announce that the Senator from Montana (Mr. BAUCUS) and the Senator from West Virginia (Mr. BYRD) are necessarily absent.

The PRESIDING OFFICER (Ms. KLOBUCHAR). Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 32, nays 66, as follows:

YEAS—32

Alexander  DeMint  McConnell
Barrasso  Ensign  Murkowski
Bayh  Gregg  Risch
Bennett  Hagan  Roberts
Bond  Grassley  Sessions
Brownback  Gehrke  Shelby
Bunning  Hatch  Snowe
Burr  Johnson  Thune
Chambliss  Isakson  Vitter
Cochran  Johanns  Voinovich
Collins  Kyl  Wicker
Corker  LeMieux

NAYS—66

Akaka  Gabilisco  Mikulski
Begich  Grassley  Murray
Bingaman  Gregg  Nelson (ND)
Bond  Harkin  Nelson (NY)
Boxer  Inouye  Pryor
Brown  Johnson  Reid
Burris  Kinaman  Rockefeller
Cardin  Kerry  Sanders
Carper  Kirk  Schumer
Chambliss  Kobuchar  Shaheen
Cochran  Landrieu  Snowe
Collins  Lautenberg  Specter
Conrad  Leahy  Stabenow
Corker  Levin  Tester
Dodd  Lieberman  Voinovich
Durbin  Lincoln  Warner
Feingold  McCaskill  Webb
Feinstein  Menendez  Whitehouse
Franken  Merkley  Wyden
The amendment (No. 2785) was rejected.

Mrs. MURRAY. Madam President, I move to reconsider the vote.

Mr. DURBIN. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

The PRESIDING OFFICER. The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed for a third reading and was read the third time.

Mrs. MURRAY. I ask for the yeas and nays.

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 98, nays 0, as follows:

[Roll Call Vote No. 352 Leg.]

YEAS—98

Baucus
Byrd
Cochran
Collins
Collins
Cochran
Conrad
Cochran
Cornyn
DeMint
Dodd
Dorgan
Durbin
Enzi
Enzi
Franken
Feingold
Feinstein
Franken
Gillibrand
Graham
Grassley
Gregg
Hagan
Hararkin
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TITLE VI—DEPARTMENT PERSONNEL MATTERS
Sec. 601. Enhancement of authorities for retention of medical professionals.
Sec. 602. Limitations on overtime duty, weekend duty, and alternative work schedules for nurses.
Sec. 603. Improvements to certain educational assistance programs.
Sec. 604. Standards for appointment and practice of physicians in Department of Veterans Affairs medical facilities.

TITLE VII—HOMELESS VETERANS MATTERS
Sec. 701. Pilot program on financial support for entities that coordinate the provision of supportive services to formerly homeless veterans residing on certain military property.
Sec. 702. Pilot program on financial support of entities that coordinate the provision of supportive services to formerly homeless veterans residing in permanent housing.
Sec. 703. Pilot program on financial support of entities that provide outreach to inform certain veterans about pension benefits.
Sec. 704. Assessment of pilot programs.

TITLE VIII—RESEARCH AND EDUCATION CORPORATIONS
Sec. 801. General authorities on establishment of corporations.
Sec. 802. Clarification of purposes of corporations.
Sec. 803. Modification of requirements for boards of directors of corporations.
Sec. 804. Clarification of powers of corporations.
Sec. 805. Redesignation of section 376A of title 38, United States Code.
Sec. 806. Improved accountability and oversight of corporations.

TITLE IX—CONSTRUCTION AND NAMING MATTERS
Sec. 901. Authorization of medical facility projects.
Sec. 902. Designation of Robley Rex Department of Veterans Affairs Medical Center.
Sec. 903. Merrill Lundman Department of Veterans Affairs Outpatient Clinic.
Sec. 904. Modification on restriction of alienation of certain real property in Gulf Port, Mississippi.

TITLE X—OTHER MATTERS
Sec. 1001. Expansion of authority for Department of Veterans Affairs police officers.
Sec. 1002. Uniform allowance for Department of Veterans Affairs police officers.

SEC. 2. REFERENCES TO TITLE 38, UNITED STATES CODE.
Except as otherwise expressly provided, whenever in this Act 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 title 38, United States Code.

TITLE I—CAREGIVER SUPPORT
SEC. 101. Waiver of Charges for Home Health Care for Ex-Service Members Accompanying Certain Severely Injured Veterans as They Receive Medical Care.
The text of section 1784 is amended to read as follows:—
"(a) IN GENERAL.—The Secretary may furnish hospital care or medical services as a humanitarian service in emergency cases.

(b) Reimbursement.—Except as provided in subsection (c), the Secretary shall charge for care and services provided under subsection (a) at rates prescribed by the Secretary.

(c) Waiver of Charges.—(1) Except as provided in paragraph (2), the Secretary shall waive charges prescribed by subsection (b) for care or services provided under subsection (a) to an attendant of a covered veteran if such care or services are provided to such attendant for an emergency that occurs while such attendant is accompanying such veteran while such veteran is receiving approved inpatient or outpatient treatment at—
(A) a Department facility; or
(B) a non-Department facility—
(i) that is under contract with the Department; or
(ii) at which the veteran is receiving fee–basis care.
If an attendant is entitled to care or services under a health-plan contract (as that term is defined in section 1725(f) of this title) or other contractual or legal recourse against a third party that would, in part, extinguish liability for charges described by subsection (b), the amount of such charges waived under paragraph (1) shall be the amount by which such charges exceed the amount of such charges covered by the health-plan contract or other contractual or legal recourse against a third party.

(d) Definitions.—In this section:
(1) The term 'attendant', with respect to a veteran, includes the following:
(A) A family member of a veteran.
(B) An individual eligible to receive ongoing family caregiver assistance under section 1717A(e)(1) of this title for the provision of personal care services to the veteran.
(C) Any other individual whom the Secretary determines—
(i) has a relationship with the veteran sufficient to demonstrate a close affinity with the veteran; and
(ii) provides a significant portion of the veteran's care.
(2) The term 'covered veteran' means any veteran with a severe injury incurred or aggravated in the line of duty in the active military, naval, or air service on or after September 11, 2001.
(3) The term 'family member' shall have such meaning as the Secretary shall determine by policy or regulation.
(4) The term 'severe injury', in the case of a covered veteran, means any physiological, psychological, or neurological condition that renders a veteran unable to live independently as determined by the Secretary.

SEC. 102. FAMILY CAREGIVER ASSISTANCE.
(a) Requirement.—
(1) IN GENERAL.—Subchapter II of chapter 17 is amended by inserting after section 1717 the following new section:
...
(4) Ongoing family caregiver assistance.—(1) Except as provided in subsection (a)(2) and subject to the provisions of this subsection, the Secretary shall provide ongoing family caregiver assistance to family members of eligible veterans (or other individuals designated by such veterans) as follows:
   (A) To each family member of an eligible veteran (or designee) who is approved under subsection (d)(3) as a personal care attendant for the veteran under subsection (e) the following:
      (i) Direct technical support consisting of information and assistance to timely address routine, emergency, and specialized caregiving needs.
      (ii) Counseling.
      (iii) Access to an interactive Internet website on caregiver services that addresses all aspects of the provision of personal care services under this section.

   (B) An eligible veteran may revoke the designation of an individual under subsection (e)(1) for the provision of personal care services to an eligible veteran if the veteran so requests.

   (2) The Secretary shall take such actions as may be appropriate concerning the revocation of a designation under paragraph (1) does not interfere with the provision of personal care services to an eligible veteran.

   (3) The Secretary shall ensure, to the extent practicable, that the schedule required by subparagraph (A) specifies that the amount of the personal caregiver stipend provided to a personal care attendant designated under subsection (e)(1) for the provision of personal care services to an eligible veteran is not less than the amount a personal care attendant designated under subsection (e)(1) for the provision of personal care services to an eligible veteran would pay an individual in the geographic area of the veteran to provide equivalent personal care services to the veteran.

   (F) If personal care services are not available from a commercial provider in the geographic area of an eligible veteran, the Secretary shall designate one family member of such veteran (or other individual designated by the veteran) as the primary personal care attendant designated by the veteran who is described by subparagraphs (A) through (E) of paragraph (2), the Secretary shall determine under paragraph (3) as a personal care attendant designated under subsection (e)(1).

   (H) An eligible veteran who may submit applications, provide consent, make a request, or concur with the request of a family member for the provision of personal care services to an eligible veteran shall terminate if the veteran no longer requires the personal care services.

   (2) To each family member of an eligible veteran (or designee) who is approved under subsection (d)(3) as a personal care attendant for the veteran under subsection (e) the following:
      (i) The ongoing family caregiver assistance described in subparagraph (A).
      (ii) Mental health and respite care.
      (iii) Respite care of not less than 30 days annually, including 24-hour per day care of the veteran commensurate with the care provided by the family caregiver to permit extended respite.

   (4) Medical care under section 1781 of this title that is appropriate for the veteran shall terminate if the veteran no longer requires the personal care services.

   (5) The Secretary shall ensure, to the extent practicable, that the schedule required by subparagraph (A) specifies that the amount of the personal caregiver stipend provided to a personal care attendant designated by the veteran for the provision of personal care services to an eligible veteran is not less than the amount a personal care attendant designated under subsection (e)(1) for the provision of personal care services to an eligible veteran would pay an individual in the geographic area of the veteran to provide equivalent personal care services to the veteran.

   (C) If personal care services are not available from a commercial provider in the geographic area of an eligible veteran, the Secretary shall designate one family member of such veteran (or other individual designated by the veteran) as the primary personal care attendant designated by the veteran who is described by subparagraphs (A) through (E) of paragraph (2), the Secretary shall determine under paragraph (3) as a personal care attendant designated under subsection (e)(1).
under subsection (f) to a family member of an eligible veteran (or other individual designated by the veteran) because of findings of an entity submitted to the Secretary under subsection (e) of this title who is not entitled to care or services under a health-plan contract as defined in section 1725(f) of this title.

(4) CONSTRUCTION.—Any family caregiver assistance furnished under section 1717A of title 38, United States Code, as added by subsection (a)(5), and annually thereafter, the Secretary shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report describing the outcome achieved under this section.

(5) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on the date that is 270 days after the date of the enactment of this Act.

(b) IMPLEMENTATION PLAN AND REPORT.—

(1) IN GENERAL.—Not later than 180 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall—

(A) submit to the Congress an implementation plan for the implementation of section 1717A of title 38, United States Code, as added by subsection (a)(1); and

(B) submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report on such plan.

(2) CONSULTATION.—In developing the plan required by paragraph (1)(A), the Secretary shall consult with the following:

(A) Veterans described in section 1717A(b) of title 38, United States Code, as added by subsection (a)(1).

(B) Family members of veterans who provide personal care services to such veterans.

(C) Veterans service organizations, as recognized by the Secretary of Veterans Affairs for the representation of veterans under section 5902 of title 38, United States Code.

(D) National caregiver networks—

(i) who specialize in the provision of assistance to individuals with the types of disabilities that personal care attendants will encounter while providing personal care services under section 1717A of title 38, United States Code, as so added.

(ii) whose caregivers are eligible to benefit from family caregiver stipends under subsection (f) of this section.

(E) Such other organizations with an interest in the provision of care to veterans as the Secretary considers appropriate.

(F) The Secretary of Defense with respect to matters concerning personal care services for members of the Armed Forces undergoing medical discharge from the Armed Forces who are eligible to benefit from family caregiver assistance furnished under section 1717A of title 38, United States Code, as so added.

(G) An assessment of the effectiveness and the efficiency of the implementation of such section.

(h) SUCH RECOMMENDATIONS, INCLUDING RECOMMENDATIONS FOR LEGISLATIVE OR ADMINISTRATIVE ACTION, AS THE SECRETARY CONSIDERS APPROPRIATE IN LIGHT OF CARRYING OUT THE REQUIREMENTS OF SUCH SECTION 1717A.

(4) REPORT ON FEASIBILITY AND ADIVISIBILITY OF EXPANDING CAREGIVER ASSISTANCE.—

In general.—Not later than two years after the date of the enactment of the Caregivers and Veterans Omnibus Health Services Act of 2009, the Secretary shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report on the feasibility and advisability of expanding family caregiver assistance under section 1717A of title 38, United States Code, as added by subsection (a)(1), to family members of veterans (or other individuals designated by such veterans) who—

(A) have a serious injury described in subsection (b)(1) of such section 1717A incurred or aggravated before September 11, 2001; and

(B) are described in paragraph (2) of such subsection.

(5) RECOMMENDATIONS.—The report required by paragraph (1) shall include such recommendations as the Secretary considers appropriate with respect to the expansion described in such paragraph.

SEC. 105. LODGING AND SUBSISTENCE FOR ATTENDANTS.

Section 111(e) is amended—

(1) by striking “When any” and inserting “(1) Any time”;

(2) in paragraph (1), as designated by paragraph (1) of this subsection—

(A) by inserting “(including lodging and subsistence)” after expenses of travel; and

(B) by inserting before the period at the end the following: “for the period consisting of travel to and from a treatment facility and the duration of the treatment episode at that facility”; and

(3) by adding at the end the following:

(2) To require attendants to use certain travel services.

(b) IN GENERAL.—The term ‘attendant’ includes, with respect to a person described in paragraph (1), the following:

(A) A family member of the person.

(B) An individual approved as a personal care attendant under section 1717A(d)(3) of this title.

(C) Any other individual whom the Secretary determines—

(i) has a preexisting relationship with the person; and

(ii) provides a significant portion of the person’s care.

(b) The term ‘family member’ shall have such meaning as the Secretary shall determine by policy or regulation.

SEC. 104. SURVEY OF INFORMAL CAREGIVERS.

(a) IN GENERAL.—The Secretary of Veterans Affairs shall, in collaboration with the Secretary of Defense, conduct a national survey of family caregivers of seriously disabled veterans and members of the Armed Forces to better understand the size and characteristics of the population of such caregivers and the types of care they provide such veterans and members.

(b) REPORT.—Not later than 60 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall, in collaboration with the Secretary of Defense,
submit to Congress a report containing the findings of the Secretary with respect to the survey conducted under subsection (a). Results of the survey shall be disaggregated by the following:

(1) Veterans and members of the Armed Forces.
(2) Veterans and members of the Armed Forces who served in Operation Iraqi Freedom or Operation Enduring Freedom.
(3) Veterans and members of the Armed Forces who live in rural areas.

TITLE II—WOMEN VETERANS HEALTH CARE MATTERS

SEC. 201. REPORT ON BARRIERS TO RECEIPT OF HEALTH CARE FOR WOMEN VETERANS.

(a) Report.—Not later than June 1, 2010, the Secretary of Veterans Affairs shall submit to the Committee on Veterans’ Affairs of the Senate of the Congress a report setting forth the response of the Department of Veterans Affairs to the findings and determinations as the entity considers appropriate in light of the report.

(b) Elements.—The report required by subsection (a) shall include the following:

(1) An identification and assessment of the following:

(A) Any stigma perceived or associated with seeking mental health care services through the Department of Veterans Affairs.
(B) The ability of women veterans to care for the Department of Veterans Affairs, and the relative frequency of use of health care services available through the Department.
(C) The quality and nature of the reception of women veterans by Department health care providers and other staff.
(D) The extent of comprehension of eligibility requirements for health care through the Department of Veterans Affairs.
(E) The availability of mental health care services available through the Department.
(F) The quality and nature of the receipt of mental health care services by women veterans under the plan at each such medical center.

(2) A review and analysis of published literature on environmental and occupational exposures of women while serving in the Armed Forces, including combat trauma, military sexual trauma, and exposure to potential teratogens associated with reproductive problems and birth defects.

(3) Responsive Report.—Not later than 90 days after the receipt of the report under paragraph (1), the Secretary shall submit to Congress a report setting forth the response of the Secretary to the findings and determinations of the entity described in subsection (a) in the report under paragraph (1).

SEC. 202. PLAN TO IMPROVE PROVISION OF HEALTH CARE SERVICES TO WOMEN VETERANS.

(a) Plan To Improve Services.—

(1) In General.—The Secretary of Veterans Affairs shall develop a plan—

(A) to improve the provision of health care services to women veterans; and
(B) to plan appropriately for the future health care needs, including mental health care needs, of veterans serving on active duty in the Armed Forces in the combat theaters of Operation Iraqi Freedom and Operation Enduring Freedom.

(2) Annual Report.—In developing the plan required by this subsection, the Secretary of Veterans Affairs shall—

(A) identify the types of health care services to be available to women veterans at each Department of Veterans Affairs medical center; and
(B) identify the personnel and other resources required to provide such services to women veterans under the plan at each such medical center.

(b) Study Required.—The Secretary of Veterans Affairs shall enter into an agreement with a non-Department of Veterans Affairs entity for conducting a study on health consequences for women veterans of service on active duty in the Armed Forces in deployment in Operation Iraqi Freedom and Operation Enduring Freedom.

(c) Specific Matters Studied.—The study under subsection (a) shall include the following:

(1) A determination of any association of environmental and occupational exposures and combat in Operation Iraqi Freedom or Operation Enduring Freedom with the general health, mental health, or reproductive health of women who served on active duty in the Armed Forces in Operation Iraqi Freedom or Operation Enduring Freedom.

(2) A review and analysis of published literature on environmental and occupational exposures of women while serving in the Armed Forces, including combat trauma, military sexual trauma, and exposure to potential teratogens associated with reproductive problems and birth defects.

(3) Responsive Report.—Not later than 18 months after entering into the agreement for the study under subsection (a), the entity described in subsection (b) shall submit to the Secretary of Veterans Affairs and to Congress a report on the study containing such findings and determinations as the entity considers appropriate in light of the report.

SEC. 203. INDEPENDENT STUDY ON HEALTH CONSEQUENCES FOR VETERANS OF MILITARY SERVICE IN OPERATION IRAQI FREEDOM AND OPERATION ENDURING FREEDOM.

(a) Study Required.—The Secretary of Veterans Affairs shall enter into an agreement with a non-Department of Veterans Affairs entity for conducting a study on health consequences for women veterans of service on active duty in the Armed Forces in deployment in Operation Iraqi Freedom and Operation Enduring Freedom.

(b) Specific Matters Studied.—The study under subsection (a) shall include the following:

(1) A determination of any association of environmental and occupational exposures and combat in Operation Iraqi Freedom or Operation Enduring Freedom with the general health, mental health, or reproductive health of women who served on active duty in the Armed Forces in Operation Iraqi Freedom or Operation Enduring Freedom.

(2) A review and analysis of published literature on environmental and occupational exposures of women while serving in the Armed Forces, including combat trauma, military sexual trauma, and exposure to potential teratogens associated with reproductive problems and birth defects.

(3) Responsive Report.—Not later than 90 days after the receipt of the report under paragraph (1), the Secretary shall submit to Congress a report setting forth the response of the Secretary to the findings and determinations of the entity described in subsection (a) in the report under paragraph (1).

SEC. 204. TRAINING AND CERTIFICATION FOR MENTAL HEALTH CARE PROVIDERS ON CARE FOR VETERANS SUFFERING FROM SEXUAL TRAUMA.

(a) Program Required.—Section 1720d is amended—

(1) by redesignating subsection (d) as subsection (f); and
(2) by inserting after subsection (f) the following new subsection:

(d)(1) The Secretary shall implement a program for education, training, certification, and continuing medical education for mental health professionals to specialize in the provision of counseling and care to veterans suffering from sexual trauma.

(b) Program in Reintegration into the Veteran’s Family, Employment, and Community.

(1) Information and counseling on conflict resolution.
(2) Financial counseling.
(3) Occupational counseling.
(4) Information and counseling on stress reduction.
(5) Information and counseling on conflict resolution.

(b) Covered Services.—The services provided to a woman veteran under the pilot program shall include the following:

(1) Information on reintegration into the veteran’s family, employment, and community.
(2) Financial counseling.
(3) Occupational counseling.
(4) Information and counseling on stress reduction.
(5) Information and counseling on conflict resolution.

(b) Covered Services.—The services provided to a woman veteran under the pilot program shall include the following:

(1) Information on reintegration into the veteran’s family, employment, and community.
(2) Financial counseling.
(3) Occupational counseling.
(4) Information and counseling on stress reduction.
(5) Information and counseling on conflict resolution.

(c) Locations.—The Secretary shall carry out the pilot program at not fewer than five locations selected by the Secretary for purposes of the pilot program.
(d) Duration.—The pilot program shall be carried out during the two-year period beginning on the date of the commencement of the pilot program.

(e) Report.—Not later than 180 days after the completion of the pilot program, the Secretary shall submit to Congress a report on the pilot program. The report shall contain the findings and conclusions of the Secretary as a result of the pilot program, and shall include such recommendations for the continuation of the pilot program as the Secretary considers appropriate.

(f) Authorization of Appropriations.—There are authorized to be appropriated to the Secretary of Veterans Affairs for each of fiscal years 2010 and 2011, $2,000,000 to carry out the pilot program.

SEC. 206. REPORT ON FULL-TIME WOMEN VETERANS PROGRAM MANAGERS AT MEDICAL CENTERS.

The Secretary shall, acting through the Under Secretary for Health, submit to Congress a report on employment of full-time women veterans program managers at Department of Veterans Affairs medical centers by insure that health care needs of women veterans are met. Such report should include an assessment of whether there is at least one full-time employee at each Department of Veterans Affairs medical center one or more of the following health care services:

1. Regular mental health care services.
2. Intensive mental health care services.
3. Such other intensive health care services that the Secretary determines that pay to the veteran for the provision of health care services described in subsection (c) to obtain child care during the period that the veteran delivered the child in—
   (1) a facility of the Department; or
   (2) another facility pursuant to a Department contract for services relating to such delivery.

(b) Covered Health Care Services.—Health care services described in this subsection are all post-delivery care services, including routine care services, that a newborn requires.

(c) Clinical Amendment.—The table of sections at the beginning of chapter 17 is amended by inserting after the item relating to section 1786 the following new item:

1786. Care for newborn children of women veterans receiving maternity care.

(TITLE III—RURAL HEALTH IMPROVEMENTS)

SEC. 301. ENHANCEMENT OF DEPARTMENT OF VETERANS AFFAIRS EDUCATION DEBT REDUCTION PROGRAM.

(a) Enhanced Maximum Annual Amount.—Paragraph (1) of section 7683(d) is amended by striking "$44,000" and all that follows through "fifth years of participation in the Program" and inserting "the total amount of principle and interest owed by the participant on loans referred to in subsection (a)".

(b) Notice to Potential Employers of Educational Assistance for Participation.—Notice to Potential Employers of Educational Assistance for Participation.

(c) Outreach.—The Secretary shall publicize the scholarship program established by the amendment made by this section.
under this chapter to educational institutions throughout the United States, with an emphasis on disseminating information to such institutions with high numbers of His-panic students and Historically Black Col- leges and Universities.

§ 7502. Application and acceptance

(a) Application.—(1) To apply and par- ticipate in the scholarship program under this chapter an individual shall submit to the Secretary an application for such par- ticipation together with an agreement de- scribed in section 7501(c)(1) of this chapter which the participant agrees to serve a pe- riod of obligated service in the Department as provided in the agreement in return for payment of educational assistance as pro- vided in the agreement.

(2) In distributing application forms and agreement forms to individuals desiring to par- ticipate in the scholarship program, the Secretary shall include with such forms the following:

(A) A fair summary of the rights and li- abilities of an individual whose application is approved of an agreement is accept- ed by the Secretary.

(B) A full description of the terms and conditions that apply to participation in the scholarship program and service in the De- partment.

(b) Approval.—(1) Upon the Secretary’s approval of an individual’s participation in the scholarship program, the Secretary shall, in writing, promptly notify the indi- vidual of that acceptance.

(2) An individual becomes a participant in the scholarship program upon such approval by the Secretary.

§ 7503. Amount of assistance; duration

(a) Amount of Assistance.—The amount of the financial assistance provided for an in- dividual under this chapter shall not exceed the amount determined by the Secretary as being necessary to pay the tuition and fees of the individual. In the case of an individual who is a full-time student in the program leading to a degree or certification in both the areas of study described in section 7501(a)(1) of this chapter, the tuition and fees shall be the amounts necessary for the minimum number of credit hours to achieve such dual certification or degree.

(b) Relationship to Other Assistance.—Financial aid may be provided to an individual under this chapter to supplement other educational assistance to the extent that the total amount of educational assistance provided to such an individual during the academic year does not exceed the total tuition and fees for such academic year.

(c) Maximum Amount of Assistance.—(1) In no case may the total amount of assist- ance provided under this chapter for an aca- demic year to an individual who is a full- time student exceed $10,000.

(2) In the case of an individual who is a part-time student, the total amount of assist- ance provided under this chapter shall bear the same ratio to the amount that would be paid under paragraph (1) if the par- ticipant were a full-time student in the pro- gram of study being pursued by the indi- vidual as the coursework carried by the indi- vidual to full-time coursework in that pro- gram of study.

(3) In no case may the total amount of assist- ance provided to an individual under this chapter exceed $4,000.

§ 7504. Agreement

An agreement between the Secretary and a participant in the scholarship program under this chapter shall be in writing, shall be signed by the participant, and shall in- clude—

(1) the Secretary’s agreement to provide the participant with educational assistance as authorized under this chapter;

(2) the participant’s agreement—

(A) to accept such financial assistance;

(B) to attend and attend- ance in the program of study described in section 7501(a)(1) of this chapter;

(C) while enrolled in such program, to maintain an acceptable level of academic standing (as determined by the educational institution offering such program under reg- ulations prescribed by the Secretary); and

(D) after completion of the program, to serve as a full-time employee in the Depart- ment for a period of three years, to be served within the first six years after the partici- pation together with an agreement de- scribed in section 7501(a)(1) of this chapter and

(3) any other terms and conditions that the Secretary determines appropriate for carrying out this chapter.
There is authorized to be appropriated to remotely and send data to a monitoring station for interpretation.

SEC. 305. DEMONSTRATION PROJECTS ON ALTERNATIVE ENDURING CARE FOR VETERANS IN RURAL AREAS.

(a) In General.—The Secretary of Veterans Affairs, through the Director of the Office of Rural Health, may carry out demonstration projects to examine the feasibility and advisability of alternatives for expanding care for veterans in rural areas, which may include the following:

(1) Establishing a partnership between the Department of Veterans Affairs and the Centers for Medicare and Medicaid Services of the Department of Health and Human Services to coordinate care for veterans in rural areas at critical access hospitals (as defined under section 1861(v)(2) of title 18, United States Code, as added by subsection (a)).

(2) Establishing a partnership between the Department of Veterans Affairs and the Department of Health and Human Services to coordinate care for veterans in rural areas at community health centers.

(3) Expanding coordination between the Department of Veterans Affairs and the Indian Health Service to expand care for Indian veterans.

(b) Geographic Distribution.—The Secretary shall ensure that the demonstration projects carried out under subsection (a) are located at facilities that are geographically distributed throughout the United States.

(c) Report.—Not later than two years after the date of the enactment of this Act, the Secretary shall submit a report on the results of the demonstration projects conducted under subsection (a) to—

(1) the Committee on Veterans’ Affairs and the Committee on Appropriations of the Senate; and

(2) the Committee on Veterans’ Affairs and the Committee on Appropriations of the House of Representatives.

SEC. 306. PROGRAM ON PROVISION OF READJUSTMENT AND MENTAL HEALTH CARE SERVICES TO VETERANS WHO SERVED IN OPERATION IRAQI FREEDOM AND OPERATION ENDURING FREEDOM.

(a) Program Required.—Not later than 180 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall establish a program to—

(1) to veterans of Operation Iraqi Freedom and Operation Enduring Freedom, particularly veterans who served in such operations while in the National Guard and the Reserve—

(A) peer outreach services;

(B) peer support services;

(C) education, support, counseling, and mental health services to assist in—

(A) the readjustment of such veteran to civilian life;

(B) in the case such veteran has an injury or illness incurred during such deployment, the recovery of such veteran and in the case such veteran dies as a result of such injury or illness, the notification of the next of kin of such veteran.

(c) slutitle return of such veteran.

(b) CONTRACTS MENTAL HEALTH CENTERS AND QUALIFIED ENTITIES FOR PROVISION OF SERVICES.—In carrying out the program required by subsection (a), the Secretary shall enter into contracts with community mental health centers and other qualified entities to provide the services required by such subsection only in areas in the Secretary determines are underserved by other health care facilities or vet centers of the Department of Veterans Affairs.

Such contracts shall require each contracting community health center or entity to—

(1) to the extent practicable, to use telehealth services for the delivery of services required by subsection (a);

(2) to the extent practicable, to employ veterans trained under subsection (c);

(3) to participate in the training program conducted in accordance with subsection (d);

(4) to comply with applicable protocols of the Department before incurring any liability on behalf of the Department for the provision of the services required by subsection (a);

(5) for each veteran for whom a community mental health center or other qualified entity provides care under such contract, to provide the Department with such clinical summary information as the Secretary shall require; and

(6) to submit annual reports to the Secretary containing, with respect to the program required by subsection (a) and for the last full calendar year ending before the submission of such report—

(A) the number of the veterans served, veterans diagnosed, and courses of treatment provided to veterans as part of the program required by subsection (a); and

(B) demographic information for such services, diagnoses, and courses of treatment; and

(7) to meet such other requirements as the Secretary shall require.

(c) TRAINING OF VETERANS FOR THE PROVISION OF PEER-OUTREACH AND PEER-SUPPORT SERVICES.—In carrying out the program required by subsection (a), the Secretary shall enter into contracts with community mental health organization to carry out a national program of training for veterans described in subsection (a) to provide the services described in paragraphs (a) and (b) of paragraph (1) of such subsection.

(d) TRAINING OF CLINICIANS FOR PROVISION OF SERVICES.—The Secretary shall conduct a training program for clinicians of community mental health centers or entities that have contracts with the Secretary under subsection (b) to ensure that such clinicians can provide the services required by subsection (a) in a manner that—

(1) recognizes factors that are unique to the experiences served on active duty in Operation Iraqi Freedom or Operation Enduring Freedom (including their combat and military training experiences); and

(2) utilizes best practices and technologies.

(e) Reports Required.—

(1) Initial Report for Implementation.—Not later than 45 days after the date of the enactment of this Act, the Secretary shall submit to the Committee on Veterans’ Affairs and the Committee on Appropriations of the Senate and the Committee on Veterans’ Affairs of the House of Representatives a report containing the plans of the Secretary to implement the program required by subsection (a).

(2) Status Report.—Not later than one year after the date of the enactment of this Act, the Secretary shall submit to the Committee on Veterans’ Affairs and the Committee on Appropriators of the Senate and the Committee on Veterans’ Affairs of the House of Representatives a report containing the plans of the Secretary to implement the program described in paragraph (1) of subsection (a), and a recommendation as to whether the period described in such paragraph should be extended to a five-year period.

SEC. 307. IMPROVEMENT OF CARE OF AMERICAN INDIAN VETERANS.

(a) Indian Health Coordinators.—

(1) Indian Health Coordinators.—

(A) Establishment.—Subchapter II of chapter 73 is amended by adding at the end the following new section:

"§7330B. Indian Veterans Health Care Coordinators

(a) In General.—(1) The Secretary shall assign at each of the 10 Department Medical Centers that serve communities with the greatest number of Indian veterans per capita as Indian Health Service official or employee to act as the coordinator of health care for Indian veterans at such Medical Center. The official or employee so assigned at a Department Medical Center shall be known as an ‘Indian Veterans Health Care Coordinator’ for the Medical Center.

(2) The Secretary shall, from time to time—

(A) survey the Department Medical Centers for purposes of identifying the 10 Department Medical Centers that currently serve communities with the greatest number of Indian veterans per capita; and

(B) utilizing the results of the most recent conducted under subparagraph (A) to the assignment of Indian Veterans Health Care Coordinators in order to assure the assignment of such coordinators to appropriate Department Medical Centers as required by paragraph (1).

(b) Duties.—The duties of an Indian Veterans Health Care Coordinator shall include the following:

(1) Improving outreach to tribal communities.

(2) Coordinating the medical needs of Indian veterans on Indian reservations with the Indian Health Service and the Indian Health Service Administration.

(3) Expanding the access and participation of Department of Veterans Affairs, the Indian Health Service, and tribal members in the Department of Veterans Affairs Tribal Veterans Representative program.

(4) Acting as an ombudsman for Indian veterans enrolled in the health care system of the Veterans Health Administration.

(5) Advocating for the incorporation of traditional medicine and healing in Department treatment plans for Indian veterans in need of care and services provided by the Department.

(c) Indian Defined.—In this section, the term ‘Indian’ has the meaning given the term in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 460a)."

(2) Clerical Amendment.—The table of sections at the beginning of chapter 73 is amended by inserting after the item relating to title 7330A the following:

"(a) 7330B. Indian Veterans Health Care Coordinators."
and Human Services shall enter into a memorandum of understanding to ensure that the health records of Indian veterans may be transferred electronically between facilities of the Indian Health Service and the Department of Veterans Affairs.

(c) TRANSFER OF MEDICAL EQUIPMENT TO THE INDIAN HEALTH SERVICE.—

(1) IN GENERAL.—The Secretary of Veterans Affairs may transfer to the Indian Health Service surplus Department of Veterans Affairs medical equipment, information technology equipment as the Secretary of Veterans Affairs and the Secretary of Health and Human Services jointly consider appropriate for purposes of the Indian Health Service.

(2) TRANSPORTATION AND INSTALLATION.—In transferring medical or information technology equipment under this subsection, the Secretary of Veterans Affairs may transport and install such equipment in facilities of the Indian Health Service.

(d) REPORT ON JOINT HEALTH CLINICS WITH INDIAN HEALTH SERVICE.—Not later than one year after the date of the enactment of this Act, the Secretary of Veterans Affairs and the Secretary of Health and Human Services shall submit to Congress a report on the feasibility and advisability of the joint establishment and operation by the Veterans Health Administration and the Indian Health Service of Indian Health clinics on reservations to serve the populations of such reservations, including Indian veterans.

SEC. 308. TRANSPORTATION IN VETERANS HEALTH ADMINISTRATION HANDBOOK.

(a) ENHANCEMENT OF ALLOWANCE BASED UPON MILEAGE TRAVELED.—Section 111 is amended—

(1) in subsection (a), by striking “traveled,” and inserting “at a rate of 41.5 cents per mile”;

(2) by amending subsection (g) to read as follows—

“(g)(1) Beginning one year after the date of the enactment of the Caregivers and Veterans Omnibus Health Services Act of 2009, the Secretary shall adjust the mileage rate described in subsection (a) to be equal to the mileage reimbursement rate for the use of privately owned vehicles by Government employees on official business (when a support vehicle is available), as prescribed by the Administrator of General Services under section 5707(b) of title 5.

“(2) If an adjustment in the mileage rate under paragraph (1) results in a lower mileage rate than the mileage rate otherwise specified in subsection (a), the Secretary shall, not later than 60 days before the date of the implementation of the mileage rate as so adjusted, submit to Congress a written report setting forth the adjustment in the mileage rate under this subsection, together with a justification for the decision to make the adjustment in the mileage rate under this subsection.”

(b) COVERAGE OF COST OF TRANSPORTATION BY AIR.—Subsection (a) of section 111, as amended, is further amended by inserting after the first sentence the following new sentence: “Actual necessary expense of travel includes the reasonable cost of travel by air and is the only practical way to reach a Department facility.”

(c) ELIMINATION OF LIMITATION BASED ON MAXIMUM ANNUAL RATE OF PENSION.—Subsection (b)(1)(D)(i) of such section is amended by inserting “who is not traveling by air and” before “whose annual.

(d) DETERMINATION OF PRACTICABILITY.—Subsection (b) of such section is amended by adding at the end the following new paragraph:

“(4) In determining for purposes of subsection (a) whether travel by air is the only practical way for a veteran to reach a Department facility, the Secretary shall consider the medical condition of the veteran and any other impediments to the use of ground transportation by the veteran.”

(e) NO EXPANSION OF ELIGIBILITY FOR BENEFICIARY TRAVEL.—The amendments made by subsection (a) of this section may not be construed as expanding, or otherwise modifying eligibility for payments or allowances for beneficiary travel under section 111 of title 38, United States Code, as in effect on the day before the date of the enactment of this Act.

(f) CLARIFICATION OF RELATION TO PUBLIC TRAVEL ALLOWANCE.—Subtitle F of chapter 55 of title 38, United States Code (Public Travel Allowance chapter), is amended by inserting after section 5507 of that title the following new section:

“SEC. 5508. PROHIBITION ON ELIGIBILITY FOR THE PUBLIC TRAVEL ALLOWANCE.

“(a) IN GENERAL.—The Secretary of Veterans Affairs may not make a travel payment to an employee (as defined in section 5503 of this title) for any travel (other than travel for which there is a military necessity) that is reimbursable under title 38, United States Code, for travel in the performance of official duties.

“(b) AMENDMENTS.—The amendments made by subsection (a) are excepted from any rule of statutory construction (other than rules of statutory construction permitting the construction of a statute to be broader than the letter of its language) that requires a construction that extends the application of such amendments beyond their terms.”

SEC. 309. OFFICE OF RURAL HEALTH FIVE-YEAR STRATEGIC PLAN.

(a) STRATEGIC PLAN.—Not later than 180 days after the date of the enactment of this Act, the Director of the Office of Rural Health of the Veterans Affairs shall develop a five-year strategic plan for the Office of Rural Health.

(b) CONTENTS.—The plan required by subsection (a) shall include the following:

(1) Specific goals for the recruitment and retention of health care personnel in rural areas, developed in conjunction with the Director of the Health Care Retention and Recruitment Office of the Department of Veterans Affairs.

(2) Specific goals for ensuring the timeliness and quality of health care delivery in rural communities that are reliant on contract and fee-basis care, developed in conjunction with the Director of the Office of Quality and Performance of the Department.

(3) Specific goals for the expansion and implementation of telemedicine services in rural areas, developed in conjunction with the Director of the Office of Care Coordination Services of the Department.

(4) Incremental milestones describing specific actions to be taken for the purpose of achieving the specific goals specified under paragraphs (1) through (3).

SEC. 310. OVERSIGHT OF CONTRACT AND FEE-BASIS CARE.

(a) IN GENERAL.—Subchapter I of chapter 17 is amended by inserting after section 1703 the following new section:

“§1703A. Oversight of contract and fee-basis care

“(a) RURAL OUTREACH COORDINATORS.—The Secretary shall designate a rural outreach coordinator at each Department community-based outpatient clinic which not less than 50 percent of the veterans enrolled at such clinic reside in a highly rural area. The coordinator at a clinic shall be responsible for reaching out to community and fee-basis providers with respect to the clinic.

“(b) INCENTIVES TO OBTAIN ACCREDITATION OF MEDICAL PRACTICE.—The Secretary shall adjust the fee-basis compensation of providers of health care services under the Department to encourage such providers to obtain accreditation of their medical practice from recognized accrediting entities.

“(c) INCENTIVES FOR PARTICIPATION IN PEER REVIEW.—(1) The Secretary shall adjust the fee-basis compensation of providers of health care services under the Department that do not provide such services as part of a medical practice accredited by a recognized accrediting entity to encourage such providers to participate in peer review under subsection (d).

“(2) The Secretary shall provide incentives under paragraph (1) to a provider of health care services under the Department in an amount which may reasonably be expected (as determined by the Secretary) to encourage participation in the voluntary peer review under subsection (d).

“(d) PEER REVIEW.—The Secretary shall provide for the voluntary peer review of providers of health care services under the Department who provide such services on a fee basis as part of a medical practice that is not accredited by a recognized accrediting entity.

“(2) Each year, beginning with the first fiscal year beginning after the date of the enactment of this section, the Chief Quality and Performance Officer in each Veterans Integrated Services Network (VISN) shall select a sample of patient records from each participating provider in the VISN to be reviewed by a facility designated under paragraph (3).

“(3) The Chief Quality and Performance Officer in each Veterans Integrated Services Network shall designate Department facilities in such network for the peer review of patient records submitted under this subsection.

“(4) Each year, beginning with the first fiscal year beginning after the date of the enactment of this section, each provider who elects to participate in the program shall submit the patient records selected under paragraph (2) to a facility selected under paragraph (3) to be peer reviewed by such facility.

“(5) Each Department facility designated under paragraph (3) that receives patient records under paragraph (4) shall—

“(A) peer review such records in accordance with policies and procedures established by the Secretary;

“(B) ensure that peer reviews are evaluated by the Peer Review Committee; and

“(C) develop a mechanism for notifying the Under Secretary for Health of problems identified through such peer review.

“(6) The Under Secretary for Health shall develop a mechanism by which the use of fee-basis providers of health care services are terminated when quality of care concerns are identified with respect to such providers.

“(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 17 is amended to include the following new section related to section 1703 the following new item:

“1703A. Oversight of contract and fee-basis care.”

SEC. 311. ENHANCEMENT OF VET CENTERS TO MEET NEEDS OF VETERANS OF OPERATION IRAQI FREEDOM AND OPERATION ENDURING FREEDOM.

(a) VOLUNTARY COUNSELORS.—

(1) IN GENERAL.—Subsection (c) of section 1712A is amended—

(A) by striking “The Under Secretary” and inserting “the Secretary”;

(B) in paragraph (1), as designated by paragraph (A), by striking “and” and inserting “and establish”;

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

“(3) INCENTIVES FOR PARTICIPATION IN PEER REVIEW.—(1) The Secretary shall adjust the fee-basis compensation of providers of health care services under the Department that do not provide such services as part of a medical practice accredited by a recognized accrediting entity to encourage such providers to participate in peer review under subsection (d).

“(2) The Secretary shall provide incentives under paragraph (1) to a provider of health care services under the Department in an amount which may reasonably be expected (as determined by the Secretary) to encourage participation in the voluntary peer review under subsection (d).

“(d) PEER REVIEW.—The Secretary shall provide for the voluntary peer review of providers of health care services under the Department who provide such services on a fee basis as part of a medical practice that is not accredited by a recognized accrediting entity.

“(2) Each year, beginning with the first fiscal year beginning after the date of the enactment of this section, the Chief Quality and Performance Officer in each Veterans Integrated Services Network (VISN) shall select a sample of patient records from each participating provider in the VISN to be peer reviewed by a facility designated under paragraph (3).

“(3) The Chief Quality and Performance Officer in each Veterans Integrated Services Network shall designate Department facilities in such network for the peer review of patient records submitted under this subsection.

“(4) Each year, beginning with the first fiscal year beginning after the date of the enactment of this section, each provider who elects to participate in the program shall submit the patient records selected under paragraph (2) to a facility selected under paragraph (3) to be peer reviewed by such facility.

“(5) Each Department facility designated under paragraph (3) that receives patient records under paragraph (4) shall—

“(A) peer review such records in accordance with policies and procedures established by the Secretary;

“(B) ensure that peer reviews are evaluated by the Peer Review Committee; and

“(C) develop a mechanism for notifying the Under Secretary for Health of problems identified through such peer review.

“(6) The Under Secretary for Health shall develop a mechanism by which the use of fee-basis providers of health care services are terminated when quality of care concerns are identified with respect to such providers.

“(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 17 is amended to include the following new section related to section 1703 the following new item:

“1703A. Oversight of contract and fee-basis care.”
services to veterans in rural areas.

Department for the furnishing of health clinical activities and systems of care for the health care professionals of the Department health services in rural areas;

(c) Activities of clinical and scientific investigation at each center operated under this section—

(A) shall be eligible to compete for the award of funding from funds appropriated for the Medical and Prosthetics Research Account; and

(B) shall receive priority in the award of funding from such account to the extent that funds are awarded to projects for research in the care of rural veterans.

SEC. 312. CENTERS OF EXCELLENCE FOR RURAL HEALTH RESEARCH, EDUCATION, AND CLINICAL ACTIVITIES.

(a) In General.—Chapter II of chapter 73, as amended by section 307 of this Act, is further amended by adding at the end the following new section:

"§ 7330C. Centers of excellence for rural health research, education, and clinical activities.

(a) Establishment of Centers.—The Secretary, through the Director of the Office of Rural Health, shall establish and operate at least one and not more than five centers of excellence for rural health research, education, and clinical activities, which shall—

(1) plan activities on the furnishing of health services in rural areas;

(2) develop specific models to be used by the Department in furnishing health services to veterans in rural areas;

(3) provide education and training for health care professionals of the Department on the furnishing of health services to veterans in rural areas; and

(4) develop and implement innovative clinical activities and systems of care for the Department for the furnishing of health services to veterans in rural areas.

(b) Use of Rural Health Resource Centers.—In selecting locations for the establishment of centers of excellence under subsection (a), the Secretary may select a rural health resource center that meets the requirements of subsection (a).

"(c) Geographic Dispersion.—The Secretary shall ensure that the centers established under this section are located at health care facilities that are geographically dispersed throughout the United States.

(d) Funding.—(1) There are authorized to be appropriated to the Medical Care Account and the Medical and Prosthetics Research Account of the Department of Veterans Affairs such sums as may be necessary for the support of the research and education activities of the centers operated under this section.

(2) There shall be allocated to the centers operated under this paragraph from amount authorized to be appropriated to the Medical Care Account and the Medical and Prosthetics Research Account by paragraph (1), such amounts as the Secretary of health considers appropriate for such centers. Such amounts shall be allocated through the Director of the Office of Rural Health.

"(e) Voluntary participation.—

(1) In General.—The Secretary shall select physicians for participation in the pilot program from among eligible physicians who—

(A) express interest in participating in the pilot program in the survey conducted under subsection (e); and

(B) are in good standing with the Department; and

(C) primarily have clinical responsibilities with the Department.

(2) Voluntary Participation.—Participation in the pilot program is voluntary. Nothing in this section shall be construed to require a physician working for the Department to assume inpatient responsibilities at a community hospital if the physician is required as a term or condition of employment with the Department.

(g) Assumption of Inpatient Physician Responsibilities.—

(1) In General.—Each eligible physician selected for participation in the pilot program shall assume and maintain inpatient responsibilities, including inpatient responsibilities with respect to nonveterans, at one or more community hospitals selected by the Secretary for participation in the pilot program under subsection (d).

(2) Coverage Under Federal Tort Claims Act.—If an eligible physician participating in the pilot program carries out on-call responsibilities at a community hospital where privileges to practice at such hospital are conditioned upon the provision of services to individuals who are not veterans while the physician is on call for such hospital, the provision of such services by the physician shall be considered an action within the scope of the physician's office or employment purposes of section 28 of United States Code (commonly referred to as the "Federal Tort Claims Act").

(h) Compensation.—

(1) In General.—The Secretary shall provide each eligible physician participating in the pilot program with such compensation (including pay and other appropriate compensation) as the Secretary determines appropriate to compensate such physician for the discharge of any inpatient responsibilities by such physician at a community hospital for which the physician would not otherwise be compensated by the Department as a full-time employee of the Department.

(2) Written Agreement.—The amount of any compensation to be provided a physician under the pilot program shall be specified in a written agreement entered into by the Secretary and the physician for purposes of the pilot program.

(3) Treatment of Compensation.—The Secretary shall consult with the Director of the Office of Personnel Management on the inclusion of a provision in a written agreement required under paragraph (2) that describes the treatment under Federal law of any compensation provided a physician under the pilot program, including treatment for purposes of retirement under the civil service laws.
SEC. 315. TRANSPORTATION GRANTS FOR RURAL VETERANS SERVICE ORGANIZATIONS.

(a) GRANTS AUTHORIZED.—

(1) IN GENERAL.—The Secretary of Veterans Affairs shall establish a grant program to provide innovative transportation options to veterans in highly rural areas.

(2) ELIGIBLE RECIPIENTS.—The following may be awarded a grant under this section:

(A) State veterans service agencies.

(B) Veterans service organizations.

(3) USE OF FUNDS.—A State veterans service agency or veterans service organization awarded a grant under this section may use the grant amount to:

(A) assist veterans in highly rural areas to travel to Department of Veterans Affairs medical facilities;

(B) otherwise assist in providing medical care to veterans in highly rural areas.

(b) ANNUAL REPORT.—The Secretary of Veterans Affairs shall submit to Congress an annual report on the pilot program required by subsection (a)(2), accompanied with documents submitted to Congress in support of the budget for the President for the fiscal year beginning in such fiscal year.

(c) USE OF FUNDS TRANSFERRED.—Funds transferred under subsection (a) shall be used for the purpose of:

(1) the provision of counseling and services under subsection (a) regardless of whether or not the member is currently on active duty in the Armed Forces at the time of receipt of counseling and services under such subsection; and

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $5,000,000 for each of fiscal years 2010 through 2014 for purposes of this section.
to award grants to support the training of psychologists in the treatment of veterans with post traumatic stress disorder, traumatic brain injury, and other combat-related disorders.

(c) PREFERENCE FOR DEPARTMENT OF VETERANS AFFAIRS HEALTH CARE FACILITIES.—In the award of grants under subsection (b) in paragraph (1) of section 1709 of the Public Law 102–585; 38 U.S.C. 527 note) is amended by striking ‘‘Not later than March 1 of each year’’ and inserting ‘‘Not later than July 1 of each of the five following years’’.

SEC. 503. PAYMENT FOR CARE FURNISHED TO CERTAIN VETERANS RECEIVING CARE.

Section 731 is amended by adding at the end the following new paragraph:

(2) The care described in this paragraph shall—

(A) hospital, nursing home, or domiciliary care;

(B) medical, rehabilitative, or preventive health services;

(C) other medical care under laws administered by the Secretary.

(b) REQUIRED DISCLOSURE OF SOCIAL SECURITY NUMBER.—(1) Any individual who applies for or is in receipt of care described in paragraph (2) shall, at the time of such application, or otherwise when requested by the Secretary, submit to the Secretary—

(A) the individual’s social security number;

and

(B) the social security number of any dependent or Department beneficiary on whose behalf, or based upon whom, such individual applies for or is in receipt of such care.

(2) The care described in this paragraph is—

(A) hospital, nursing home, or domiciliary care;

(B) medical, rehabilitative, or preventive health services;

(C) other medical care under laws administered by the Secretary.

(c) PREFERENCE FOR DEPARTMENT OF VETERANS AFFAIRS HEALTH CARE FACILITIES.—In the award of grants under section 1709 of the Public Law 102–585; 38 U.S.C. 527 note) is amended by striking ‘‘Not later than March 1 of each year’’ and inserting ‘‘Not later than July 1 of each of the five following years’’.

SEC. 504. DISCLOSURES FROM CERTAIN MEDICAL RECORDS.

Section 732i(b)(2) is amended by adding at the end the following new subparagraph:

(2) The care described in this paragraph shall—

(A) hospital, nursing home, or domiciliary care;

(B) medical, rehabilitative, or preventive health services;

(C) other medical care under laws administered by the Secretary.

SEC. 505. DISCLOSURE TO SECRETARY OF HEALTH-PLAN CONTRACT INFORMATION AND SOCIAL SECURITY NUMBER OF CERTAIN VETERANS RECEIVING CARE.

(a) IN GENERAL.—Subchapter I of chapter 17 is amended by adding at the end the following new section:

"§ 1709b. Disclosure to Secretary of health-plan contract information and social security number of certain veterans receiving care

(2) The care described in this paragraph is—

(A) hospital, nursing home, or domiciliary care;

(B) medical, rehabilitative, or preventive health services;

(C) other medical care under laws administered by the Secretary.

(b) REQUIRED DISCLOSURE OF SOCIAL SECURITY NUMBER.—(1) Any individual who applies for or is in receipt of care described in paragraph (2) shall, at the time of such application, or otherwise when requested by the Secretary, submit to the Secretary—

(A) the individual’s social security number;

and

(B) the social security number of any dependent or Department beneficiary on whose behalf, or based upon whom, such individual applies for or is in receipt of such care.

(2) The care described in this paragraph is—

(A) hospital, nursing home, or domiciliary care;

(B) medical, rehabilitative, or preventive health services;

(C) other medical care under laws administered by the Secretary.

(c) FAILURE TO DISCLOSE SOCIAL SECURITY NUMBER.—(1) The Secretary shall deny an individual’s application for, or may terminate an individual’s enrollment in, the system of patient enrollment established by the Secretary under section 1705 of this title, if such individual does not provide the social security number required or requested to be submitted pursuant to paragraph (2).

(2) Following a denial or termination under paragraph (1) with respect to an individual, the Secretary may, upon receipt of the information required or requested under subsection (b), approve such individual’s application or reinstate such individual’s enrollment (if otherwise in order), for such medical care and services provided on and after the date of such receipt of information.

(d) CONSTRUCTION.—Nothing in this section shall be construed as authority to deny medical care and treatment to an individual in a medical emergency.

(b) CLERICAL AMENDMENT.—The table of sections at the end of chapter 17 is amended by inserting after the item relating to section 1708 the following new item:

"1709b. Disclosure to Secretary of health-plan contract information and social security number of certain veterans receiving care.".

SEC. 506. ENHANCEMENT OF QUALITY MANAGEMENT.

(a) ENHANCEMENT OF QUALITY MANAGEMENT THROUGH QUALITY MANAGEMENT OFFICERS.—

(1) IN GENERAL.—Subchapter II of chapter 73 is amended by inserting after section 7311 the following new section:

"§ 7311A. Quality management officers

(1) NATIONAL QUALITY MANAGEMENT OFFICER.—(1) The Under Secretary for Health shall designate an official of the Veterans Health Administration to act as the principal quality management officer for the quality-assurance program required by section 7311 of this title. The official so designated shall be the National Quality Management Officer of the Veterans Health Administration (in this section referred to as the ‘‘National Quality Management Officer’’).

(2) The National Quality Management Officer shall report directly to the Under Secretary for Health in the discharge of responsibilities and duties of the Officer under this section.

(2) The National Quality Management Officer shall be the official within the Veterans Health Administration who is principally responsible for the quality-assurance program required by section 7311 of this title. In carrying out that responsibility, the Officer shall be responsible for the following:

(A) Establishing and enforcing the requirements of the program referred to in paragraph (1).

(B) Developing an aggregate quality metric from existing data sources, such as the Performance Evaluation and Improvement Department, the National Surgical Quality Improvement Program, and the External Peer Review Program of the Veterans Health Administration, that could be used to assess reliably the quality of care provided at individual Department medical centers and associated community based outpatient clinics.

(C) Ensuring that existing measures of quality, including measures from the Inpatient Evaluation Center, the National Surgical Quality Improvement Program, System-Wide Ongoing Assessment and Review reports of the Department, and Combined Assessment Program reviews of the Office of Inspector General, are monitored routinely and analyzed in a manner that ensures the timely detection of quality of care issues.

(D) Encouraging research and development in the area of quality metrics for the purposes of improving how the Department measures quality in individual facilities.

(E) Carrying out all responsibilities and duties relating to quality management in the Veterans Health Administration as the Under Secretary for Health shall specify.

(3) The requirements under paragraph (3) shall include requirements regarding the following:

(A) A confidential system for the submittal of reports by Veterans Health Administration personnel regarding quality management at Department facilities.

(B) Mechanisms for the peer review of the actions of individuals appointed in the Veterans Health Administration in the position of physician.

(C) QUALITY MANAGEMENT OFFICERS FOR VISNS.—(1) The Regional Director of each Veterans Integrated Service Network (VISN) shall appoint an individual to act as the quality management officer of the VISN.

(2) The quality management officer for a Veterans Integrated Service Network shall report to the Regional Director of the Veterans Integrated Service Network, and to the National Quality Management Officer, regarding the discharge of the responsibilities and duties of the officer under this section.

(3) The quality management officer for a Veterans Integrated Service Network shall—

(A) direct the quality management office in the Network, and

(B) coordinate, monitor, and oversee the quality management programs and activities of the Quality Management Officer at Department facilities in the Network in order to ensure the thorough and uniform discharge of quality management requirements under such programs and activities throughout the Network.

(C) QUALITY MANAGEMENT OFFICERS FOR MEDICAL FACILITIES.—(1) The director of each Veterans Health Administration medical facility shall appoint a quality management officer for that facility.

(2) The quality management officer for a facility shall report directly to the Director of the facility, and to the quality management officer of the Veterans Integrated Services Network.
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Services Network in which the facility is located, regarding the discharge of the responsibilities and duties of the quality management officer under this section.

(3) Such recommendations as the Secretary considers appropriate for legislative or administrative action to improve the authoritie s and requirements in such sections and the amendments made by such sections or to otherwise improve the quality of health care and the quality of the physicians in the Veterans Health Administration.

(b) CONGRESSIONAL VETERANS AFFAIRS COMMITTEES DEFINED.—In this section, the term "congressional veterans affairs committees" means—

(1) the Committees on Veterans' Affairs and Appropriations of the Senate; and

(2) the Committees on Veterans' Affairs and Appropriations of the House of Representatives.

SEC. 508. PILOT PROGRAM ON USE OF COMMUNITY-BASED ORGANIZATIONS AND LOCAL AND STATE GOVERNMENT ENTITIES TO ENSURE THAT VETERANS RECEIVE CARE AND BENEFITS FOR WHICH THEY ARE ELIGIBLE.

(a) PILOT PROGRAM REQUIRED.—The Secretary of Veterans Affairs shall carry out a pilot program to assess the feasibility and advisability of using community-based organizations and local and State government entities—

(1) to increase the coordination of community, local, and State government providers of health care and benefits for veterans to assist veterans who are transitioning from military service to civilian life in such transition;

(2) to increase the availability of high quality medical and mental health services to veterans transitioning from military service to civilian life;

(3) to provide assistance to families of veterans who are transitioning from military service to civilian life to help such families adjust to such transition; and

(4) to provide outreach to veterans and their families to inform them about the availability of benefits and connect them with appropriate care and benefit programs.

(b) DURATION OF PROGRAM.—The pilot program shall be carried out during the two-year period beginning on the date of the enactment of this Act.

(c) PROGRAM LOCATIONS.—

(1) IN GENERAL.—The pilot program shall be carried out at five locations selected by the Secretary for purposes of the pilot program.

(2) CONSIDERATIONS.—In selecting locations for the pilot program, the Secretary shall consider the advisability of selecting locations in—

(A) rural areas;

(B) areas with populations that have a high proportion of minority group representation;

(C) areas with populations that have a high proportion of individuals who have limited access to health care; and

(D) areas that are not in close proximity to an active duty military installation.

(d) GRANTS.—The Secretary shall carry out the pilot program through the award of grants to community-based organizations and local and State government entities.

(1) IN GENERAL.—A community-based organization or local or State government entity seeking a grant under the pilot program shall submit to the Secretary of Veterans Affairs an application therefor in such form and in such manner as the Secretary considers appropriate.

(2) ELIGIBILITY.—Such application submitted under paragraph (1) shall include the following:

(A) A description of the proposal was developed in consultation with the Department of Veterans Affairs.

(B) A plan to coordinate activities under this program, to the extent possible, with the local, State, and Federal providers of services for veterans to reduce duplication of services and to increase the effect of such services.

(C) USE OF GRANT FUNDS.—The Secretary shall prescribe appropriate uses of grant funds received under the pilot program.

(d) REPORT ON PILOT PROGRAM.—

(1) IN GENERAL.—Not later than 180 days after the completion of the pilot program, the Secretary shall submit to Congress a report on the pilot program.

(2) ELEMENTS.—The report required by paragraph (1) shall include the following:

(A) The findings and conclusions of the Secretary with respect to the pilot program.

(B) An assessment of the benefits to veterans of the pilot program.

(C) The recommendations of the Secretary as to the advisability of continuing the pilot program.

SEC. 509. SPECIALIZED RESIDENTIAL CARE AND REHABILITATION FOR CERTAIN VETERANS.

Section 1720 is amended by adding at the end the following new subsection:

(a) IN GENERAL.—Not later than 90 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall enter into a contract with the Institute of Medicine of the National Academies to conduct an expanded study on the health impact of Project Shipboard Hazard and Defense (Project SHAD).

(b) COVERED VETERANS.—The study required by subsection (a) shall include, to the extent practicable, all veterans who participated in Project Shipboard Hazard and Defense.

(c) UTILIZATION OF EXISTING STUDIES.—The study required by subsection (a) may use results from the study covered in the report entitled "Long-Term Health Effects of Participation in Project SHAD" of the Institute of Medicine of the National Academies.

SEC. 511. USE OF COMMUNITY-BASED ORGANIZATIONS FOR REHABILITATION OF INDIVIDUALS WITH TRAUMATIC BRAIN INJURY.

Section 1710E is amended—

(1) by redesignating subsection (b) as subsection (c);

(2) by inserting after subsection (a) the following new subsection (b):

(3) to provide assistance to families of veterans who are transitioning from military service to civilian life; and

(4) to provide outreach to veterans and their families to inform them about the availability of benefits and connect them with appropriate care and benefit programs.

(b) DURATION OF PROGRAM.—The pilot program shall be carried out during the two-year period beginning on the date of the enactment of this Act.

(c) PROGRAM LOCATIONS.—

(1) IN GENERAL.—The pilot program shall be carried out at five locations selected by the Secretary for purposes of the pilot program.

(2) CONSIDERATIONS.—In selecting locations for the pilot program, the Secretary shall consider the advisability of selecting locations in—

(A) rural areas;

(B) areas with populations that have a high proportion of minority group representation;

(C) areas with populations that have a high proportion of individuals who have limited access to health care; and

(D) areas that are not in close proximity to an active duty military installation.

(d) GRANTS.—The Secretary shall carry out the pilot program through the award of grants to community-based organizations and local and State government entities.

(1) IN GENERAL.—A community-based organization or local or State government entity seeking a grant under the pilot program shall submit to the Secretary of Veterans Affairs an application therefor in such form and in such manner as the Secretary considers appropriate.

(2) ELIGIBILITY.—Such application submitted under paragraph (1) shall include the following:

(A) A description of the proposal was developed in consultation with the Department of Veterans Affairs.

(B) A plan to coordinate activities under this program, to the extent possible, with the local, State, and Federal providers of services for veterans to reduce duplication of services and to increase the effect of such services.

(C) USE OF GRANT FUNDS.—The Secretary shall prescribe appropriate uses of grant funds received under the pilot program.

(d) REPORT ON PILOT PROGRAM.—

(1) IN GENERAL.—Not later than 180 days after the completion of the pilot program, the Secretary shall submit to Congress a report on the pilot program.

(2) ELEMENTS.—The report required by paragraph (1) shall include the following:

(A) The findings and conclusions of the Secretary with respect to the pilot program.

(B) An assessment of the benefits to veterans of the pilot program.

(C) The recommendations of the Secretary as to the advisability of continuing the pilot program.

(a) IN GENERAL.—Not later than 90 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall enter into a contract with the Institute of Medicine of the National Academies to conduct an expanded study on the health impact of Project Shipboard Hazard and Defense (Project SHAD).

(b) COVERED VETERANS.—The study required by subsection (a) shall include, to the extent practicable, all veterans who participated in Project Shipboard Hazard and Defense.

(c) UTILIZATION OF EXISTING STUDIES.—The study required by subsection (a) may use results from the study covered in the report entitled "Long-Term Health Effects of Participation in Project SHAD" of the Institute of Medicine of the National Academies.

Section 1710E is amended—

(1) by redesignating subsection (b) as subsection (c);

(2) by inserting after subsection (a) the following new subsection (b):

(3) to provide assistance to families of veterans who are transitioning from military service to civilian life; and

(4) to provide outreach to veterans and their families to inform them about the availability of benefits and connect them with appropriate care and benefit programs.

(b) DURATION OF PROGRAM.—The pilot program shall be carried out during the two-year period beginning on the date of the enactment of this Act.

(c) PROGRAM LOCATIONS.—

(1) IN GENERAL.—The pilot program shall be carried out at five locations selected by the Secretary for purposes of the pilot program.

(2) CONSIDERATIONS.—In selecting locations for the pilot program, the Secretary shall consider the advisability of selecting locations in—

(A) rural areas;

(B) areas with populations that have a high proportion of minority group representation;

(C) areas with populations that have a high proportion of individuals who have limited access to health care; and

(D) areas that are not in close proximity to an active duty military installation.

(d) GRANTS.—The Secretary shall carry out the pilot program through the award of grants to community-based organizations and local and State government entities.

(1) IN GENERAL.—A community-based organization or local or State government entity seeking a grant under the pilot program shall submit to the Secretary of Veterans Affairs an application therefor in such form and in such manner as the Secretary considers appropriate.

(2) ELIGIBILITY.—Such application submitted under paragraph (1) shall include the following:

(A) A description of the proposal was developed in consultation with the Department of Veterans Affairs.

(B) A plan to coordinate activities under this program, to the extent possible, with the local, State, and Federal providers of services for veterans to reduce duplication of services and to increase the effect of such services.

(C) USE OF GRANT FUNDS.—The Secretary shall prescribe appropriate uses of grant funds received under the pilot program.

(d) REPORT ON PILOT PROGRAM.—

(1) IN GENERAL.—Not later than 180 days after the completion of the pilot program, the Secretary shall submit to Congress a report on the pilot program.

(2) ELEMENTS.—The report required by paragraph (1) shall include the following:

(A) The findings and conclusions of the Secretary with respect to the pilot program.

(B) An assessment of the benefits to veterans of the pilot program.

(C) The recommendations of the Secretary as to the advisability of continuing the pilot program.
(3) by adding at the end the following new subsection:

"(d) STANDARDS.—The Secretary may not provide treatment or services as described in subsection (a) at a State Department facility under such subsection unless such facility maintains standards for the provision of such treatment or services established by an independent, peer-reviewed organization that accredits specialized rehabilitation programs for adults with traumatic brain injury.".

SEC. 513. PILOT PROGRAM ON PROVISION OF DENTAL INSURANCE PLANS TO VETERANS AND SURVIVORS AND DEPENDENTS OF VETERANS.

(a) PILOT PROGRAM REQUIRED.—The Secretary of Veterans Affairs shall carry out a pilot program to assess the feasibility and advisability of offering a dental insurance plan to veterans and survivors and dependents of veterans described in subsection (b).

(b) COVERED VETERANS AND SURVIVORS AND DEPENDENTS.—A covered veteran, survivor, and dependent shall be eligible for a dental insurance plan provided under the pilot program if such veteran, survivor, and dependent is treated as a State home under subsection (a).

(c) PILOT PROGRAM LOCATIONS.—The pilot program shall be carried out during the three-year period beginning on the date of enactment.

(d) PILOT PROGRAM DELETIONS.—Each pilot program shall be in such amount or related to such language as the Secretary shall prescribe for purposes of the pilot program.

(e) ADMINISTRATION.—The Secretary of Veterans Affairs shall contract with a dental insurance plan provider to carry out the pilot program.

(f) PAYMENTS.—The dental insurance plan under the pilot program shall provide such dental benefits as the Secretary determines appropriate for the dental insurance plan, including diagnostic services, preventative services, endodontic and other restorative services, surgical services, and emergency services.

(g) ENROLLMENT.—(1) VOLUNTARY.—Enrollment in the dental insurance plan under this section shall be voluntary.

(2) MINIMUM PERIOD.—Enrollment in the dental insurance plan shall be for such minimum period as the Secretary shall prescribe for purposes of this section.

(h) PREMIUMS.—(1) IN GENERAL.—Premiums for coverage under the pilot program shall be in such amount or related to such language as the Secretary of Veterans Affairs shall prescribe to cover all costs associated with the pilot program.

(2) ANNUAL ADJUSTMENT.—The Secretary shall adjust the premiums payable under the pilot program to ensure that the total amount payable under the pilot program is sufficient to cover all costs associated with the pilot program.

(3) RESPONSIBILITY FOR PAYMENT.—Each individual covered by the dental insurance plan shall pay the entire premium for coverage under the dental insurance plan on an annual basis. Each individual in the dental insurance plan at the time of such an adjustment shall be notified of the amount and effective date of such adjustment.

(4) PAYMENT.—Each individual enrolled in the dental insurance plan shall pay the entire premium for coverage under the dental insurance plan on an annual basis.

(i) VOLUNTARY DISENROLLMENT.—(1) IN GENERAL.—With respect to enrollment in the dental insurance plan under the pilot program, the Secretary shall—

(A) permit the voluntary disenrollment of an individual in the dental insurance plan if the disenrollment occurs during the three-year period beginning on the date of the enrollment of the individual in the dental insurance plan; and

(B) permit the voluntary disenrollment of an individual in the dental insurance plan for such circumstances as the Secretary shall prescribe for purposes of this subsection, provided that such disenrollment does not jeopardize the fiscal integrity of the dental insurance plan.

(j) RELATIONSHIP TO DENTAL CARE PROVIDED BY SECRETARY.—The dental insurance plan shall be administered under such regulations as the Secretary shall prescribe.

SEC. 514. EXPANSION OF ELIGIBILITY.—(a) EXPANSION OF ELIGIBILITY.—The Medicare program established in section 1807 of title 42, United States Code, and the Medicaid program established in section 1903 of title 42, United States Code, shall be administered under such regulations as the Secretary shall prescribe for the purposes of this section.

(b) LIMITATIONS ON PAYMENTS.—(1) IN GENERAL.—With respect to coverage under the Medicare program, the Secretary of Veterans Affairs shall carry out a pilot program to assess the feasibility and advisability of offering a dental insurance plan to veterans and survivors and dependents of veterans described in subsection (b). The pilot program shall be in such amount or related to such language as the Secretary shall prescribe, except that the amount payable may not exceed the maximum amount payable under subparagraph (A).

(2) IN CIRCUMSTANCES.—(A) If an individual enrolled in the dental insurance plan is responsible under a health-plan contract for payment of an amount payable by the third party, except that the amount payable may not exceed the maximum amount payable under subparagraph (A) of section 1571 of title 38, United States Code, and the Secretary determines that such individual is voluntarily disenrolling under such circumstances as the Secretary shall prescribe, such individual shall continue to be subject to the provisions of such circumstances as the Secretary shall prescribe for purposes of this section.

(b) LIMITATIONS ON PAYMENTS.—(1) IN GENERAL.—With respect to coverage under the Medicare program, the Secretary of Veterans Affairs shall carry out a pilot program to assess the feasibility and advisability of offering a dental insurance plan to veterans and survivors and dependents of veterans described in subsection (b).

(2) PILOT PROGRAM LOCATIONS.—The pilot program shall be in such amount or related to such language as the Secretary shall prescribe for purposes of the pilot program.

(3) ESTABLISHMENT OF PROCEDURES.—The Secretary shall establish procedures for determinations on the eligibility of such determinations.

SEC. 515. PILOT PROGRAM ON PROVISION OF DENTAL INSURANCE PLANS TO VETERANS AND SURVIVORS AND DEPENDENTS OF VETERANS.

(a) PILOT PROGRAM REQUIRED.—The Secretary of Veterans Affairs shall carry out a pilot program to assess the feasibility and advisability of offering a dental insurance plan to veterans and survivors and dependents of veterans described in subsection (b).

(b) COVERED VETERANS AND SURVIVORS AND DEPENDENTS.—A covered veteran, survivor, and dependent shall be eligible for a dental insurance plan provided under the pilot program.

(c) PILOT PROGRAM LOCATIONS.—The pilot program shall be carried out during the three-year period beginning on the date of the enactment.

(d) PILOT PROGRAM DELETIONS.—Each pilot program shall be in such amount or related to such language as the Secretary shall prescribe for purposes of the pilot program.

(e) ADMINISTRATION.—The Secretary of Veterans Affairs shall contract with a dental insurance plan provider to carry out the pilot program.

(f) PAYMENTS.—The dental insurance plan under the pilot program shall provide such dental benefits as the Secretary determines appropriate for the dental insurance plan, including diagnostic services, preventative services, endodontic and other restorative services, surgical services, and emergency services.

(g) ENROLLMENT.—(1) VOLUNTARY.—Enrollment in the dental insurance plan under this section shall be voluntary.

(2) MINIMUM PERIOD.—Enrollment in the dental insurance plan shall be for such minimum period as the Secretary shall prescribe for purposes of this section.

(h) PREMIUMS.—(1) IN GENERAL.—Premiums for coverage under the pilot program shall be in such amount or related to such language as the Secretary of Veterans Affairs shall prescribe to cover all costs associated with the pilot program.

(2) ANNUAL ADJUSTMENT.—The Secretary shall adjust the premiums payable under the pilot program to ensure that the total amount payable under the pilot program is sufficient to cover all costs associated with the pilot program.

(3) RESPONSIBILITY FOR PAYMENT.—Each individual covered by the dental insurance plan shall pay the entire premium for coverage under the dental insurance plan on an annual basis.

(i) VOLUNTARY DISENROLLMENT.—(1) IN GENERAL.—With respect to enrollment in the dental insurance plan under the pilot program, the Secretary shall—

(A) permit the voluntary disenrollment of an individual in the dental insurance plan if the disenrollment occurs during the three-year period beginning on the date of the enrollment of the individual in the dental insurance plan; and

(B) permit the voluntary disenrollment of an individual in the dental insurance plan for such circumstances as the Secretary shall prescribe for purposes of this subsection, provided that such disenrollment does not jeopardize the fiscal integrity of the dental insurance plan.

(j) RELATIONSHIP TO DENTAL CARE PROVIDED BY SECRETARY.—The dental insurance plan shall be administered under such regulations as the Secretary shall prescribe.
(B) in subparagraph (B), by inserting before the period at the end the following: “including a State Medicaid agency with respect to payments made under a State plan for medical assistance approved under title XIX of such Act (42 U.S.C. 1396 et seq.).”

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by subsection (b) shall take effect on the date of the enactment of this Act, and shall apply with respect to emergency treatment furnished on or after that date.

(2) REMUNERATION FOR TREATMENT BEFORE EFFECTIVE DATE.—The Secretary of Veterans Affairs may provide reimbursement under section 1725 of title 38, United States Code, as applicable with respect to the veteran, it is determined that, under the circumstances applicable with respect to the veteran, it is appropriate to do so.

SEC. 515. PROHIBITION ON COLLECTION OF CO-PAYMENTS FROM VETERANS WHO ARE CATASTROPHICALLY DISABLED.

(a) IN GENERAL.—Subchapter III of chapter 17 is amended by adding at the end the following new subsection:

“(j) 1730A. Prohibition on collection of copayments from catastrophically disabled veterans.—

“Notwithstanding subsections (f) and (g) of section 1722A(a) of this title or any other provision of law, the Secretary may not require a veteran who is catastrophically disabled to make any copayment for the receipt of hospital care or medical services under the laws administered by the Secretary.”.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of this chapter is amended by inserting after the item relating to section 1730 the following new item:

“1730A. Prohibition on collection of copayments from catastrophically disabled veterans.”.

TITLE VI—DEPARTMENT PERSONNEL MATTERS

SEC. 601. ENHANCEMENT OF AUTHORITIES FOR RETENTION OF MEDICAL PROFESSIONALS.

(a) SECRETARIAL AUTHORITY TO EXTEND TITLE 38 STATUS TO ADDITIONAL POSITIONS.—

(1) IN GENERAL.—Paragraph (3) of section 7401 is amended by striking “and blind rehabilitation outpatient specialists,” and inserting “blind rehabilitation outpatient specialists, and such other classes of health care occupations as the Secretary considers necessary for the recruitment and retention of highly qualified Department personnel subject to the following requirements:

“(A) Such other classes of health care occupations—

“(i) are not occupations relating to administrative, clerical, or physical plant maintenance and protective services;

“(ii) that would otherwise receive basic pay in the General Schedule under section 5322 of title 5;

“(iii) provide, as determined by the Secretary, direct patient care services or services incident to direct patient services; and

“(iv) would not otherwise be available to provide medical care or treatment for veterans;

“(B) Not later than 45 days before the Secretary appoints any personnel for a class of health care occupations that is not specifically listed in this paragraph, the Secretary shall consult with the National Council on Veterans’ Affairs of the Senate, the Committee on Veterans’ Affairs of the House of Representatives, and the Office of Management and Budget, and shall—

“(C) Before submitting notice under subsection (B), the Secretary shall solicit comments from any labor organization representing employees in such class and include such comments in such notice.”.

(2) APPOINTMENT OF NURSE ASSISTANTS.—Such paragraph is further amended by inserting “nurse assistants,” after “licensed practical or vocational nurses.”.

(b) PROBATIONARY PERIODS FOR REGISTERED NURSES.—Section 7402 is amended—

(1) in paragraph (1), by striking “Appointment” and inserting “Except as otherwise provided in this subsection, appointments”; and

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

(3) by inserting after paragraph (1) the following new paragraphs—

“(2) With respect to the appointment of a registered nurse under this chapter, paragraph (1) shall apply with respect to such appointment regardless of whether such appointment is on a full-time basis or a part-time basis.

“(3) An appointment described in subsection (a) on a part-time basis of a person who has previously served on a full-time basis for the probationary period for the position concerned shall be without a probationary period.

(c) PROHIBITION ON TEMPORARY PART-TIME REGISTERED NURSE APPOINTMENTS IN EXCESS OF TWO YEARS.—Section 7405 is amended by adding at the end the following new subsection:

“'(g)(1) Except as provided in paragraph (3), employment of a registered nurse on a temporary part-time basis for two years of section 5382 of title 5 as if such position were a Senior Executive Service position (as such term is defined in section 3132(a) of title 5).

'(2) Except as provided in paragraph (3), upon completion by a registered nurse of the probationary period described in paragraph (1)—

'(A) the employment of such nurse shall—

'(i) no longer be considered temporary; and

'(ii) be considered an appointment described in section 7406(a) of this title; and

'(B) the nurse shall be considered to have served the probationary period required by section 7405(b).

'(3) This subsection shall not apply to appointments made on a term limited basis of less than or equal to three years of—

'(A) nurses with a part-time appointment resulting in certification or designation as an ambulatory care provider or teaching position in a nursing academy of the Department;

'(B) nurses appointed as a result of a specific research proposal or grant; or

'(C) nurses who are not citizens of the United States and appointed under section 7407(a) of this title.

'(d) WAIVER OF OFFSET FROM PAY FOR CER
tax Reemployed Annuitants.—

(1) IN GENERAL.—Section 7406, as amended by section 3 of title 5, is amended by adding at the end the following new subsection:

“(h) The Secretary may, by issuing regulations, provide that such annuitant is entitled to receive benefits under this section without offset from any other pay, and that such annuitant is entitled to receive benefits under section 7406(b) as if such annuitant were a former employee of the Department.

(2) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act and shall apply to pay periods beginning on or after such effective date.

(e) RATE OF BASIC PAY FOR APPOINTEES TO THE OFFICE OF THE UNDER SECRETARY FOR HEALTH SHT TO RATE OF BASIC PAY FOR SENIOR EXECUTIVE SERVICE POSITIONS.—

(1) IN GENERAL.—Section 7409(a) is amended—

(A) by striking “The annual” and inserting “(1) The annual”; and

(B) by striking “The pay” and inserting the following:

“(2) The pay”;

and

(2) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act and shall apply to pay periods beginning on or after such effective date.

(f) SPECIAL INCENTIVE PAY FOR DEPART
dent Pharmacist Executives.—Section 7410 is amended—

(1) by striking “The Secretary may” and inserting the following:

“(a) IN GENERAL.—The Secretary may”;

and

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

“(b) SPECIAL INCENTIVE PAY FOR DEPART
dent Pharmacist Executives.—(1) In order to recruit and retain highly qualified Department pharmacist executives, the Secretary may authorize the Under Secretary for Health to pay special incentive pay of not more than $60,000 per year to an individual of the Veterans Health Administration who is a pharmacist executive.

(2) EFFECTIVE DATE.—The amendments made by this section shall apply to the first day of the first pay period beginning after the date that is 180 days after the date of the enactment of this Act.”
"(c) The personal qualifications of the individual.

"(d) The characteristics of the labor market concerned.

"(e) Other factors as the Secretary considers appropriate.

"(3) Special incentive pay under paragraph (1) for an individual shall not be considered basic pay for purposes of adverse actions under section V of this chapter.

"(6) Special incentive pay under paragraph (1) may not be awarded to an individual in an amount that would result in an aggregate amount of pay (including bonuses and awards) received by such individual in a year under this title that is greater than the annual pay of the President.

"(7) PAY FOR PHYSICIANS AND DENTISTS.—

"(1) NON-FOREIGN COST OF LIVING ADJUSTMENT ALLOWANCE.—Section 7431(b) is amended by adding at the end the following new paragraph:

"(4) the non-significant cost of living adjustment allowance authorized under section 5941 of title 5 for physicians and dentists whose pay is set under this section shall be determined as a percentage of base pay only.

"(2) MARKET PAY DETERMINATIONS FOR PHYSICIANS AND DENTISTS IN ADMINISTRATIVE OR EXECUTIVE LEADERSHIP POSITIONS.—Section 7451(c)(4)(v)(i) is amended by adding at the end the following: ‘‘The Secretary may exempt physicians and dentists occupying administrative or executive leadership positions from the requirements of the previous sentence.’’

"(3) EXCEPTION TO PROHIBITION ON REDUCTION OF MARKET PAY.—Section 7431(c)(7) is amended by striking ‘‘concerned,’’ and inserting ‘‘concerned, unless there is a change in board certification or reduction of privileges.’’

"(h) ADJUSTMENT OF PAY CAP FOR NURSES.—Section 7451(c)(2) is amended by striking ‘‘level 3’’ and inserting ‘‘level IV’’.

"(i) EXEMPTION FOR CERTIFIED REGISTERED NURSE ANESTHETISTS FROM LIMITATION ON AUTHORIZED COMPETITIVE PAY.—Section 7451(c)(1) is amended by adding at the end the following new paragraph: ‘‘The maximum rate of basic pay for a grade for the position of certified registered nurse anesthetist pursuant to an adjustment under subsection (d) may exceed the maximum rate otherwise provided in the preceding sentence.’’

"(j) INCREASED LIMITATION ON SPECIAL PAY FOR NURSE EXECUTIVES.—Section 7452(g)(2) is amended by striking ‘‘$25,000’’ and inserting ‘‘$100,000’’.

"(k) LOCALITY PAY SCALE COMPUTATIONS.—

"(1) EDUCATION, TRAINING, AND SUPPORT FOR FACILITY DIRECTORS IN WAGE SURVEYS.—Section 7451(d)(3) is amended by adding at the end the following new subparagraph: ‘‘(E) the work involves work for which the Secretary has exhausted all good faith reasonable attempts to obtain voluntary workers;’’

"(2) MARKET PAY DETERMINATIONS FOR PHYSICIANS AND DENTISTS IN ADMINISTRATIVE OR EXECUTIVE LEADERSHIP POSITIONS.—Section 7451(c)(4)(v)(i) is amended by adding at the end the following new paragraph: ‘‘The Secretary may exempt physicians and dentists occupying administrative or executive leadership positions from the requirements of the previous sentence.’’

"(3) DISCLOSURE OF INFORMATION TO PERSONS REQUESTING INFORMATION.—Section 7456A(b) is amended—

"(a) OVERTIME DUTY.—

"(1) IN GENERAL.—Subchapter IV of chapter 74 is amended by adding at the end the following new section:

"7459. Nursing staff: special rules for overtime duty.

"(a) LIMITATION.—Except as provided in subsection (c), the Secretary may not require nursing staff to work more than 40 hours in a work week or more than eight consecutive days in an administrative work week or more than eight consecutive 24-hour periods if such staff is covered under section 7456 or 7456A of this title.

"(b) VOLUNTARY OVERTIME.—(1) Nursing staff may elect to work hours otherwise prohibited by subsection (a).

"(2) The refusal of nursing staff to work hours prohibited by subsection (a) shall not be grounds to discriminate (within the meaning of section 70(a)(a) of the Civil Rights Act of 1964 (42 U.S.C. 2000e-3(a)) against the staff, dismissal or discharge of the staff, or any other adverse personnel action against the staff.

"(c) OVERTIME UNDER EMERGENCY CIRCUMSTANCES.—Subparagraph (2) of section 7456A of this title is amended—

"(1) the Secretary may require nursing staff to work hours otherwise prohibited by subsection (a) if—

"(A) the work is a consequence of an emergency that could not have been reasonably anticipated;

"(B) the emergency is non-recurring and is not caused by or aggravated by the inattention of the Secretary or lack of reasonable contingency planning by the Secretary;

"(C) the Secretary has exhausted all good faith reasonable attempts to obtain voluntary workers;

"(D) the nurse staff have critical skills and expertise that are required for the work; and

"(E) the work involves work for which the standard of care for a patient assignment requires continuity of care through completion of a case, treatment, or procedure.

"(2) Nursing staff may not be required to work hours under this subsection after the requirement for a direct role by the staff in responding to medical needs resulting from the emergency ends.

"(d) NURSING STAFF DEFINED.—In this section, the term ‘nursing staff’ includes the following:

"(1) A registered nurse.

"(2) A licensed practical or vocational nurse.

"(3) A nurse assistant appointed under this chapter or title 5.

"(4) Any other nurse position designated by the Secretary for purposes of this section.

"(2) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 74 is amended by inserting after the item relating to section 7456 the following new item:

"7459. Nursing staff: special rules for overtime duty.

"(b) WEEKEND DUTY.—Section 7456 is amended—

"(1) by striking subsection (c); and

"(2) by redesignating subsection (d) as subsection (c).

"(c) OVERTIME SCHEDULES.—

"(1) IN GENERAL.—Section 7456A(b)(1)(A) is amended by striking ‘‘three regularly scheduled’’ and all that follows through the period at the end and inserting in lieu thereof scheduled 12-hour tours of duty within a 14-day period shall be considered for all purposes to have worked a full 80-hour pay period.

"(2) CONFORMING AMENDMENTS.—Section 7456A(b) is amended—
the following new section:

section 7402A. Appointment and practice of physicians: standards

(a) IN GENERAL.—The Secretary shall, acting through the Under Secretary for Health, prescribe standards to be met by individuals in order to be appointed in the Veterans Health Administration in the position of physician and to practice as a physician in medical facilities of the Administration. The Secretary shall incorporate the requirements of this section.

(b) DISCLOSURE OF CERTAIN INFORMATION REQUIRED FOR APPOINTMENT.—If an individual seeking appointment in the Veterans Health Administration in the position of physician shall do the following:

(1) Provide the Secretary a full and complete explanation of the following:

(A) Each lawsuit, civil action, or other claim (whether open or closed) brought against the individual for medical malpractice or negligence;

(B) Each payment made by or on behalf of the individual to settle any lawsuit, action, or claim covered by subparagraph (A); and

(C) Each investigation or disciplinary action taken against the individual relating to the individual’s performance as a physician.

(2) Provide the Secretary a written authorization permitting the State licensing board of each State in which the individual holds or has held a license to practice medicine to disclose to the Secretary any information in the records of such State on the following:

(A) Each lawsuit, civil action, or other claim brought against the individual for medical malpractice or negligence covered by paragraph (1)(A) that occurred in such State;

(B) Each payment made by or on behalf of the individual to settle any lawsuit, action, or claim covered by subparagraph (A); and

(C) Each investigation or disciplinary action taken or under consideration against the individual by an administrative agency or body of such State.

(3) Any change in the status of the license to practice medicine issued the individual by any administrative agencies or bodies of such State.

(4) Any written notification by the Secretary to the individual of potential termination of a license for cause or otherwise.

(c) DISCLOSURE OF CERTAIN INFORMATION FOLLOWING APPOINTMENT.—(1) Each individual appointed in the Veterans Health Administration in the position of physician shall, as part of the biennial review of the performance of the physician under the appointment, submit the request and authorization described in subsection (b) as a condition of service under the appointment, to disclose to the Secretary, not later than 30 days after the occurrence of such event, the following:

(A) A judgment against the individual for medical malpractice or negligence;

(B) A payment made by or on behalf of the individual to settle any lawsuit, action, or claim disclosed pursuant to subparagraph (A) or under this subparagraph;

(2) If any matters have been disclosed under section 7402A, the Director of the Veterans Health Administration in the position of physician shall perform an investigation (in a manner so specified of each matter disclosed under subsection (b) with respect to the individual.

(3) The Director of the Veterans Integrated Services Network in which an individual is appointed shall perform an investigation (in a manner so specified) of each matter disclosed under subsection (b) with respect to the individual.

(d) INVESTIGATION OF DISCLOSED MATTERS.—(1) The Director of the Veterans Integrated Services Network (VISN) in which an individual is seeking appointment shall perform an investigation (in such manner as specified) of each matter disclosed under subsection (b) with respect to the individual.

(e) APPROVAL OF APPOINTMENTS BY DIRECTOR OF VISN.—If the Director of any VISN determines that an individual may not be appointed in the Veterans Health Administration in the position of physician without the approval of the Director of the Veterans Health Administration, the Director shall first approve the appointment, unless the medical center director and credentialing and privileging manager of the facility hiring the physician certifies in writing that:

(A) A full investigation was carried out in compliance with section 104 of this title; and

(B) An investigation did not disclose any actions described in subsections (b), (c), and (d) of such section.

(2) In approving the appointment under this section of any individual, the Director shall—

(A) certify in writing the completion of the performance of the investigation under subsection (d)(1) of each such matter, including the results of such investigation; and

(B) provide a written justification why any matters raised in the course of such investigation do not disqualify the individual from appointment.

(f) ENROLLMENT OF PHYSICIANS WITH PRIVILEGE TO DISCLOSE SERVICE.—Each medical facility of the Department at which physicians are extended the privileges of practice shall enroll each practicing physician who discloses a covered facility in the Proactive Disclosure Service of the National Practitioner Data Bank.
SEC. 701. PILOT PROGRAM ON FINANCIAL SUPPORT FOR ENTITIES THAT COORDINATE THE PROVISION OF SUPPORTIVE SERVICES TO FORMERLY HOMELESS VETERANS RESIDING ON CERTAIN MILITARY PROPERTY.

(a) Establishment.—

(1) In general.—Subject to the availability of appropriations for such purpose, the Secretary of Veterans Affairs may carry out a pilot program to make grants to public and nonprofit organizations (including faith-based and community organizations) to coordinate the provision of supportive services available in the local community to very low income, formerly homeless veterans residing in permanent housing on certain military property of the Department of Defense.

(b) Number of Grants.—The Secretary shall make grants at up to 10 qualifying properties under this section and shall publish such criteria and requirements in the Federal Register.

(c) Duration of Program.—The authorities of the Secretary to provide grants under this section shall cease on the date that is five years after the date of the commencement of the pilot program.

(d) Authorization of Appropriations.—There is authorized to be appropriated for programs with similar purposes, more than $3,000,000 in each of fiscal years 2010 through 2014 to carry out the purposes of this section.

SEC. 702. PILOT PROGRAM ON FINANCIAL SUPPORT FOR ENTITIES THAT COORDINATE THE PROVISION OF SUPPORTIVE SERVICES TO FORMERLY HOMELESS VETERANS RESIDING IN PERMANENT HOUSING.

(a) Establishment of Pilot Program.—

(1) In general.—Subject to the availability of appropriations for such purpose, the Secretary of Veterans Affairs may carry out a pilot program to make grants to public and nonprofit organizations (including faith-based and community organizations) to coordinate the provision of supportive services available in the local community to very low income, formerly homeless veterans residing in permanent housing.

(b) Number of Grants.—The Secretary may make grants at up to 10 qualifying properties under the pilot program.

(c) Qualifying Property.—Qualifying property under this program is any property in the United States on which permanent housing is provided or afforded to formerly homeless veterans, as determined by the Secretary.

(d) Duration of Program.—The authorities of the Secretary to provide grants under this section shall cease on the date that is five years after the date of the commencement of the pilot program.

(e) Authorization of Appropriations.—There is authorized to be appropriated for programs with similar purposes, more than $3,000,000 in each of fiscal years 2010 through 2014 to carry out the purposes of this section.

SEC. 703. PILOT PROGRAM ON FINANCIAL SUPPORT FOR ENTITIES THAT PROVIDE OUTREACH TO INFORM CERTAIN VETERANS ABOUT PENSION BENEFITS.

(a) Authority To Make Grants.—In addition to the amounts available under the heading ‘‘General Operating Expenses’’, the Secretary may carry out a pilot program to make grants to nonprofit organizations, including faith-based and community organizations, for services to provide outreach to inform low-income and elderly veterans who reside in rural areas of benefits for which they may be eligible under chapter 15 of title 38.

(b) Criteria for Grants.—The Secretary shall prescribe criteria and requirements for grants under this section and shall publish such criteria and requirements in the Federal Register.

(c) Duration of Program.—The authority of the Secretary to provide grants under this section shall cease on the date that is five years after the date of the commencement of the pilot program.

(d) Authorization of Appropriations.—There is authorized to be appropriated for programs with similar purposes, more than $1,275,000 in each of fiscal years 2010 through 2014 to carry out the purposes of this section.

SEC. 704. ASSESSMENT OF PILOT PROGRAMS.

(a) Progress Reports.—Not less than one year before the expiration of the authority to carry out a pilot program authorized by sections 501 through 503, the Secretary of Veterans Affairs shall submit to Congress a progress report on such pilot program.

(b) Contents.—Each progress report submitted for a pilot program under subsection (a) shall include the following:

(1) The lessons learned by the Secretary of Veterans Affairs with respect to the pilot program that can be applied to other programs with similar purposes.

(2) The recommendations of the Secretary on whether to continue the program.

(c) The number of veterans and dependents served by such pilot program.

(d) An analysis of the quality of service provided to veterans and dependents under such pilot program.

(e) The names of organizations that have received grants under such pilot program.

TITLE VIII—NONPROFIT RESEARCH AND EDUCATION CORPORATIONS

SEC. 801. GENERAL AUTHORITIES ON ESTABLISHMENT OF CORPORATIONS.

(a) Authorization of Multi-Medical Center Research Corporations.—

(1) In general.—Section 7381 is amended—

(A) by redesigning subsection (b) as subsection (e); and

(B) by inserting after subsection (a) the following new subsection (d):

‘‘(d) Subject to paragraph (2), a corporation established under this subchapter may facilitate the conduct of research, education, or both at more than one medical center. Such a corporation shall be known as a ‘multi-medical center research corporation’.’’

(b)(1) In general.—The board of directors of a multi-medical center research corporation under this subchapter shall include the official at each Department medical center concerned who is, or who carries out the responsibilities of, the medical center director of such center as specified in section 7363(a)(1)(A)(i) of this title.

(2) In facilitating the conduct of research, education, or both at more than one Department medical center under this subchapter, such corporation may administer receipts and expenditures relating to such research, education, or both, as applicable, performed at the Department medical centers concerned.

(2) Expansion of Existing Corporations to Multi-Medical Center Research Corporations.—Such section is further amended by adding at the end the following new subsection:

‘‘(c) A corporation established under this subchapter may act as a multi-medical center research corporation under this subchapter in accordance with subsection (b) if—

(1) the board of directors of the corporation approves a resolution permitting facilitation by the corporation of the conduct of..."
research, education, or both at the other Department medical center or medical centers concerned; and

(2) the Secretary approves the resolution of the dispute.

(b) RESTATEMENT AND MODIFICATION OF AUTHORITY ON APPLICABILITY OF STATE LAW.—

(1) IN GENERAL.—Section 7361, as amended by subsection (a) of this section, is further amended by inserting after subsection (b) the following new subsection (c):

``(c) Any corporation established under this subchapter shall be established in accordance with the nonprofit corporation laws of the State in which the applicable Department medical center or medical centers located and in accordance with the nonprofit corporation laws of the State in which one of such Department medical centers is located.

(2) CONFORMING AMENDMENT.—Section 7365 is repealed.

(c) CLARIFICATION OF STATUS OF CORPORATIONS.—Section 7361, as amended by this section, is further amended—

(1) in subsection (a), by striking the second sentence;

(2) by inserting after subsection (c) the following new subsection (d):

``(d) Except as otherwise provided in this subchapter, and unless the official or officials who are responsible for carrying out the responsibilities of such position or positions at the Department medical center, and''

(b) MODIFICATION OF DEFINED TERM RELATING TO EDUCATION AND TRAINING.—Subsection (b) of section 7366 is amended by striking the item relating to section 7364A(1) of such Act, further amended by striking the last sentence.

``(b) TRANSFER AND ADMINISTRATION OF FUNDS.—(1) Except as provided in paragraph (2), any funds received by the Secretary for the conduct of research or education at a Department medical center or medical centers other than funds appropriated to the Department, may be transferred to and administered by a corporation established under this subchapter for such purposes.

``(2) A Department medical center may re-imburs the corporation for all or a portion of the pay, benefits, or both of an employee of the corporation who is assigned to the Department medical center if the assignment is carried out pursuant to subchapter VI of chapter 33 of title 38.

(3) A Department medical center may retain and use funds provided to it by a corporation established under this subchapter for education facilitated under section 7364."
“(c) Any audit under this paragraph shall be performed by an independent auditor.

“(3) The corporation shall include in each report to the Secretary under paragraph (1) the following:

“(A) The most recent audit of the corporation under paragraph (2).

“(B) The most recent Internal Revenue Service determination of organizational exemption from Income Tax’’ or equivalent and the applicable schedules under such form.

“(c) Confirmation of application of conflicts of interest regulations to appropriate corporation positions.—Subsection (c) of such section is amended—

“(1) by striking ‘‘laws and’’ each place it appears;

“(2) in paragraph (1)—

“(A) by inserting ‘‘each officer and’’ after ‘‘under this subchapter’’; and

“(B) by striking ‘‘and each employee of the Department’’ and all that follows through ‘‘during any year’’; and

“(3) in paragraph (2)—

“(A) by inserting ‘‘, officer’’ after ‘‘verifying that each director’’; and

“(B) by striking ‘‘in the same manner’’ and all that follows before the period at the end.

“(c) Confirmation of application of conflicts of interest regulations to appropriate corporation positions.—Subsection (d)(3)(C) of such section is amended by striking ‘‘$5,000’’ and inserting ‘‘$50,000’’.

“TITLE IX—CONSTRUCTION AND NAMING MATTERS

SEC. 901. AUTHORIZATION OF MEDICAL FACILITY PROJECTS.

(a) Authorization of Fiscal Year 2010 Major Medical Facility Projects.—The Secretary of Veterans Affairs may carry out the following major medical facility projects in fiscal year 2010, with each project to be carried out in the amount specified for each project:

(1) Construction (including acquisition of land) for the realignment of services and closure of a Department of Veterans Affairs Medical Center in Livermore, California, in an amount not to exceed $55,430,000.

(2) Construction of a Multi-Specialty Care Facility in Walla Walla, Washington, in an amount not to exceed $71,400,000.

(3) Construction (including acquisition of land) for a new medical facility at the Department of Veterans Affairs Medical Center in Louisville, Kentucky, in an amount not to exceed $194,400,000.

(4) Construction (including acquisition of land) for a clinical expansion for a Mental Health Facility at the Department of Veterans Affairs Medical Center in Dallas, Texas, in an amount not to exceed $15,640,000.

(5) Construction (including acquisition of land) for a replacement bed tower and clinical expansion at the Department of Veterans Affairs Medical Center in St. Louis, Missouri, in an amount not to exceed $31,300,000.

(b) Authorization of Fiscal Year 2010 Major Medical Facility Construction Projects Previously Authorized.—The Secretary of Veterans Affairs may carry out the following major medical facility projects in fiscal year 2010, as follows with each project to be carried out in the amount specified for that project:

(1) Replacement of the existing Department of Veterans Affairs Medical Center in Denver, Colorado, in an amount not to exceed $360,000,000.

(2) Replacement of the Outpatient and Inpatient Improvements in Bay Pines, Florida, in an amount not to exceed $194,400,000.

(c) Authorization of Appropriations.—

(1) Authorization for construction.—There is authorized to be appropriated to the Secretary of Veterans Affairs for fiscal year 2010, or the year in which funds are appropriated, for the Construction, Major Projects account—

(A) $260,610,000 for the projects authorized in subsection (a);

(B) $994,400,000 for the projects authorized in subsection (b).

(2) Limitation.—The projects authorized in subsections (a) and (b) may only be carried out using—

(A) funds appropriated for fiscal year 2010 pursuant to the authorization of appropriations in paragraph (1) of this section;

(B) funds available for Construction, Major Projects for a fiscal year before fiscal year 2010 that remain available for obligation;

(C) funds available for Construction, Major Projects for a fiscal year after fiscal year 2010 that remain available for obligation;

(D) funds appropriated for Construction, Major Outpatient Clinics; and

(F) funds appropriated for Construction, Major Projects for a fiscal year after 2010 for a category of activity not specific to a project; and

(Fund) funds appropriated for Construction, Major Projects for a fiscal year after 2010 for a category of activity not specific to a project.

SEC. 902. DESIGNATION OF ROBLEY REX MEDICAL DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTER.

(a) Designation.—The Department of Veterans Affairs Medical Center in Louisville, Kentucky, known as the Merril Lundman Department of Veterans Affairs Medical Center, shall after the date of enactment of this Act be known and designated as the ‘‘Robley Rex Department of Veterans Affairs Medical Center’’.

(b) References.—Any reference in any law, regulation, map, document, record, or other paper of the United States to the medical center referred to in subsection (a) shall be considered to be a reference to the Robley Rex Department of Veterans Affairs Medical Center.

SEC. 903. MERRIL LUNDMAN DEPARTMENT OF VETERANS AFFAIRS OUTPATIENT CLINIC.

(a) In General.—The Department of Veterans Affairs outpatient clinic in Havre, Montana, shall after the date of the enactment of this Act be known and designated as the ‘‘Merril Lundman Department of Veterans Affairs Outpatient Clinic’’.

(b) References.—Any reference in any law, regulation, map, document, record, or other paper of the United States to the outpatient clinic referred to in subsection (a) shall be considered to be a reference to the Merril Lundman Department of Veterans Affairs Outpatient Clinic.

SEC. 904. MODIFICATION ON RESTRICTION OF ALIENATION OF CERTAIN REAL PROPERTY IN GULF PORT, MISSISSIPPI.

(a) In General.—Section 2703(b) of the Emergency Supplemental Appropriations Act for Defense, Global War on Terror, and Hurricane Recovery, 2006 (Public Law 109–234; 120 Stat. 469), as amended by section 251 of the Military Construction and Veterans Affairs and Related Agencies Appropriations Act, 2009 (division E of Public Law 110–329; 122 Stat. 3713), is further amended by inserting after ‘‘the City of Gulfport’’ the following:—

‘‘or its urban renewal agency’’.

(b) Memorialization of Modification.—The Secretary of Veterans Affairs shall take appropriate actions to modify the qui tam decree executed by the corporation authorized by section 2703 of the Emergency Supplemental Appropriations Act for Defense, the Global War on Terror, and Hurricane Recovery, 2006 (Public Law 109–234) in order to accurately reflect and memorialize the amendment made by subsection (a).

SEC. 1001. EXPANSION OF AUTHORITY FOR DEPARTMENT OF VETERANS AFFAIRS POLICE OFFICERS.

Section 902 is amended—

(1) in subsection (a)—

(A) by amending paragraph (1) to read as follows—

‘‘(1) Employees of the Department who are Department police officers shall, with respect to acts occurring on Department premises—

(A) enforce Federal laws; and

(B) enforce the rules prescribed under section 901 of this title;’’;

(2) by striking paragraph (2) and redesignating paragraph (3) as paragraph (2); and

(3) by amending subsection (c) to read as follows:

‘‘(c) The powers granted to Department police officers designated under this section shall be exercised in accordance with guidelines approved by the Secretary and the Attorney General.’’

SEC. 1002. UNIFORM ALLOWANCE FOR DEPARTMENT OF VETERANS AFFAIRS POLICE OFFICERS.

Section 903 is amended—

(1) by amending subsection (b) to read as follows—

‘‘(b) The amount of the allowance that the Secretary may pay under this section is the lesser of—

(A) the amount currently allowed as prescribed by the Office of Personnel Management; or

(B) estimated costs or actual costs as determined by periodic surveys conducted by the Department.

(2) During any fiscal year no officer shall receive more for the purchase of a uniform described in subsection (a) than the amount established under this subsection.’’;

(3) by striking subsection (c) and inserting the following new subsection (c):

‘‘(c) The allowance established under subsection (b) shall be paid to the officer in each case in the manner prescribed by the Office of Personnel Management; and

‘‘(d) In carrying out any act to which this section applies, the Secretary shall ensure that the Department establishes and administers a system to ensure that the Department pays in full, and on a timely basis, all valid claims for services furnished by Department police officers during the period for which the claims are incurred under this section.’’.

Mrs. MURRAY. Madam President, I move to reconsider the vote and I move to lay that motion on the table.

The motion to lay on the table was agreed to.

The PRESIDING OFFICER. The Senator from Washington is recognized.
MORNING BUSINESS

Mrs. MURRAY. Madam President, I ask unanimous consent to have the Senate proceed to a period of morning business with Senators permitted to speak for up to 10 minutes each.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mrs. MURRAY. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. GRASSLEY. Madam President, I ask unanimous consent the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

HEALTH CARE REFORM

Mr. GRASSLEY. Madam President, we have been waiting for many weeks while the Democratic leadership worked behind closed doors to write a new health care reform bill. Rather than trying to build consensus for a bill that could get broad-based support, they went about it the hard way, but at long last this new health care reform plan is finally public. They have come forward with this new health care reform plan is finally public. They have come forward to at last reveal the legislative language for a health care reform bill that the Democrats intend to bring to the floor.

We know where they started. We know the changes they made along the way. Those in this Chamber will recall that we worked for months in the Senate Finance Committee on health reform. Senator BAUCUS and I worked very carefully in committee to try to develop a bipartisan reform plan.

Health care, as everybody knows, is one-sixth of the economy. If that economic fact is obscure to people, $1 out of every 6 spent in the United States is spent on health care.

We are, of course, to spend upward of $33 trillion on health care in this country over the next decade—$33 trillion. Already our health care system is on an unsustainable path. Our current health care entitlement programs, at least the two, Medicare and Medicaid, are both on very unsound financial footing. Not only are both programs in jeopardy financially, but the magnitude of the problem is a real threat to the Federal budget.

Starting in 2008, the Medicare Program began spending more out of the hospital insurance trust fund than it is taking in. That deficit spending at the trust fund is the beginning of the end of Medicare unless Congress steps in and does something to maintain that trust fund. The Medicare trustees have been warning us for years that the hospital insurance fund—the trust fund, that is—is going to go broke. They now predict that year of going broke is 2017.

To keep the four financial tireires means finding a way to bridge the gap for the $75 trillion of unfunded liability, and this must be done in a manner that does not worsen the health care quality or access for beneficiaries. Likewise, the Medicaid Program, which serves 59 million low-income pregnant women as well as children and the families, is on a very shaky financial ground.

We have the Government Accountability Office reporting to Congress that States—meaning the 50 States—are reaching a crisis with their part of the Medicaid Program. The Government Accountability Office models predict that State spending will grow faster than State revenues for at least the next 10 years. The impact of declining revenues is very clear. I quote what the GAO has said about this situation:

"Since most state and local governments are required to balance their operating budgets, the declining fiscal conditions shown in our simulations suggest, that without intervention, these governments would need to make substantial policy changes to avoid growing fiscal imbalances."

This, too, is the crisis facing the Medicaid Program today. So both of the two major Federal health care programs are in very serious trouble. It seems only one of the most significant implications for our entire country and the 300 or more million people who live here. If reforms to health care are not done carefully—and I say "carefully because I am not saying we should not do it—this is going to make the situation far worse, not better. Anyone listening would have no doubt of the ability of Congress to make it worse.

These dire economic implications are not the only thing at stake with health care reform. Besides the significant economic implications of health care reform, this is a bill that affects everyone in another very important way. It affects everyone's health by changing the way we get health care in this country. It touches the lives of every family, every senior, every child, every student. In plain language, it affects everybody: the 306 million people who live here now and the many more people who will be living here in the future.

It makes changes to health care that will be nearly impossible to undo. The reforms these bills contemplate will make long lasting changes to our health care system. These are changes that all of us will have to live with for decades to come. Health care reform presents this Chamber with a bill that has significant economic implications at a time when all eyes are focused on the economy, so focused on the economy that it almost reminds me of how President Clinton got elected on the campaign slogan, "It's the economy, stupid." This health care reform bill is a bill that will make permanent changes to our system of health care.

For all of these reasons, it makes it all the more important that changes of significance should be done with broad-based support; in other words, health care is a life-or-death issue for every American, and it affects $1 out of every $6 spent in America. Because it is so big, that is the basis for that statement—"broad-based support."

Under the leadership of Senator BAUCUS, chairman of the Finance Committee, we started last year with a bipartisan health care reform summit. We held 20 hearings. We held three public forums this year on options for financing, coverage, and delivery system reform. We invited in experts from across the country. We invited anyone to submit input to the committee on those options, and we received over 600 sets of comments on the option papers.

Senator BAUCUS and I developed the broad outlines of what we believed would be a good reform package. That broad outline reflected the input we had from that very open and public process. We took it and we sat down with four other leaders on the issue of health care in this very Chamber. That group soon became known as the group of six. That group began meeting in June to take that framework and finish the details. We met for untold hours. We consulted with experts at the Congressional Budget Office and the Joint Committee on Taxation. We invested a tremendous amount of time and effort to develop a bipartisan package.

Then what happens around here too often? People get impatient. In this case, the Democratic leaders got impatient. They wanted the reform bill to be finished faster. They were more concerned with health care reform getting done right now rather than getting done right. We said we needed to give the process the time it needed. We said we were not going to be bound by arbitrary deadlines. We wanted to get the job done right. But when the first of September rolled around, they were not willing to give the group of six any more time.

As a result, the Democratic leaders pulled the plug on that bipartisan effort and the hope for broad bipartisan support ended at that point. Ultimately, the Finance Committee reported out a bill that did not have that broad bipartisan support, the support we had hoped for earlier in the year. The bigger and more liberal agenda driven by the White House and the Democratic leadership went beyond where the true consensus on reform exists.

Now the next step in this process has begun to emerge to be a bill from the HELP Committee to the Finance Committee. That job fell to the Democratic leader and the chairman of the two committees. But, ultimately, their...
leader even excluded the chairmen from the process. That process began on October 2. So the rest of the Senate has been waiting ever since that time to see what would emerge from behind closed doors just across the hall.

But I started to complain about how long it was taking to develop the merged bill. When that happened, lo and behold, we started to hear from the Democratic leader what the group of six had been saying. That leader, too, was saying he was not going to be bound by any artificial timeline. He, too, started saying he was going to take whatever time he needed. Imagine our shock and dismay when we heard this. All the impatience we heard about how long our bipartisan process was taking, the criticism we took.

So they pulled the plug on that effort out of impatience. My suspicion is that only now is there a realization of how hard it is to assemble a comprehensive health care reform plan. Now at long last, that merged bill is before us. Now we know what is in it. The bill has undergone many changes since the Democrats decided to do a partisan bill. They are not positive. They have moved more and more to not only a partisan agenda, they have moved to an extreme agenda. It is an agenda so extreme, they are having difficulty finding votes among Democratic Members. They have 60-vote control of this body. They have an overwhelming majority in the House. Yet they are trying to blame Republicans for slowing down the process.

Surely they don’t expect 100 Senators to get this done faster than it took a leader behind closed doors to get the bill done, to put together the two bills between the Finance Committee and the HELP Committee, what we have before us or will eventually have before us. But it is not Republicans who are slowing the process and more to not only a partisan agenda, they have moved to an extreme agenda. It is an agenda so extreme, they are having difficulty finding votes among Democratic Members. They have 60-vote control of this body. They have an overwhelming majority in the House. Yet they are trying to blame Republicans for slowing down the process.

I yield the floor.

The PRESIDING OFFICER (Mrs. McCaskill). The Senator from Colorado.

Mr. BENNET. Madam President, I am pleased to be here today with my colleagues from New Hampshire to talk about fiscal accountability in the context of the health care reform discussion we have been having.

Back in Colorado, people are not talking about far-left or far-right or Democratic or Republican. That is not what concerns them. What concerns them is that for the last 10 years they and our colleagues in health care reform work of 3 months during the summer. I hope at some point they will want to let that bipartisan work begin again. Then they need to back that effort and give it the time needed to get it right rather than getting it done right now. It is clear that today is not the day that is going to happen.

We must pass effective reform that will rein in skyrocketing costs in both the public and private sectors and help solve the fiscal problems that threaten our economy and our kids’ futures. Without reform, if we just hold on to the status quo, if we listen to the siren call of special interests, out-of-control health care costs will place an even higher burden on government budgets and create deficits that could persist for decades as a drag on economic recovery and growth, with deficits and debt for as far as our eyes can see.

Rising health care costs—especially Medicare costs—are the largest driver of our deficits. Our Nation’s health care spending today is 17 percent of our gross domestic product. It is slated to grow to over 20 percent in the blink of an eye. Health care will soon account for one-fifth of our economy. That is more than if every other industrialized country in the world was not devoting less than half of that as a percentage of their GDP to health care premiums for millions to over people’s lives. It still will cause a lot of government power in Washington that is already alarming special interests to get in the way of our passing meaningful health care reform for working families and small businesses. At the same time, we have tripled our Federal budget deficits and added to the national debt, as we have been unable to deliver for families all across the United States.

Well, today we are closer than ever to meaningful health care reform that lowers costs, reduces the Nation’s long-term deficits, and improves access to affordable health care for Colorado’s working families. With the release of the Patient Protection and Affordable Care Act, we have taken a major step forward. This bill will help put our Nation back on a track to fiscal responsibility. We must do all we can to get us where we need to be. I am the father of three little girls who are 10, 8, and 5, and I am desperate about the amount of debt we have loaded up on our Federal Government, about the Federal deficit and Federal debt. While reforming health care is not sufficient to fix that problem, it is a very important step forward. Our Nation’s annual deficits are enormous and our debt is staggering. Health care reform, as I said, must help solve that problem, not make it worse.

I, for one, have said from the very beginning of this debate that I would not support a health care reform bill that added a dollar to our deficit. I am very clear about what I believe. I believe that the leader has produced does not do that.

We must pass effective reform that will rein in skyrocketing costs in both the public and private sectors and help solve the fiscal problems that threaten our economy and our kids’ futures. Without reform, if we just hold on to the status quo, if we listen to the siren call of special interests, out-of-control health care costs will place an even higher burden on government budgets and create deficits that could persist for decades as a drag on economic recovery and growth, with deficits and debt for as far as our eyes can see.

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health care. It is like having two small businesses, one across the street from the other, and one is spending a fifth of their revenue on their light bill and the one across the street is spending less than half that. You do not need an MBA to know which of those small businesses is going to be able to stay in business and grow. If we expect to be able to compete in the global economy, we need to devote a smaller percentage of our GDP to health care.

Since 1970, every year for almost 40 years—year-in and year-out—Medicare spending per person has risen by over 8 percent a year and private insurance spending per person has risen by over 9 percent a year. We cannot expect reform to begin at the private or employer-based level. We must drive these costs down at the Federal level by reorienting our Medicare incentive structure.

The Congressional Budget Office Director, Doug Elmendorf, has said that the "rising costs for health care represent the single greatest challenge to balancing the federal budget." If you are embracing the status quo, you are embracing skyrocketing deficits.

The White House Budget Director, Peter Orszag, agrees, saying: "The single most important thing—"the single most important thing"—we can do to put the nation on a sounder long-term fiscal footing is to reduce the rate of growth of health care costs. Period.

Meanwhile, the cost of health insurance is eating into family budgets faster and faster. About 20 years ago, the cost of an average family health care policy was $4,700 in Colorado, representing 12 percent of the average family’s income. Today, an average family’s health care policy costs roughly $12,000, amounting to 20 percent of the family’s income, going, by 2016, if we do nothing, to 40 percent of their income.

Middle-class wages are not even close to keeping up with these rising insurance costs. In fact, median family income in this country fell by $300 as health care costs increased by 80 percent just while the last administration was in office.

Looking outside the confines of the budget context, health care reform will contribute significantly to economic growth. Health care reform will rein in skyrocketing health care costs and achieve close to $2 trillion of savings through the entire health care system—savings that will result in real economic gains to families and businesses. The Council of Economic Advisers estimates that slowing health care costs will increase our gross domestic product by 2 percent in 2020 and by 8 percent in 2030.

After 8 years of irresponsible deficit spending, this legislation will be budget-neutral and will put us on course to reduce the deficit over the long term. It is no wonder that people doubt this is actually happening because it has been so long since this body was actually able to do something that was deficit neutral. In this case, we are actually going to improve our deficit situation.

The Congressional Budget Office report confirms that the Senate bill is fiscally responsible and will reduce the deficit. According to the CBO, the bill cuts the budget deficit by $130 billion over 10 years; cuts the budget deficit by $650 billion in the second decade; extends coverage to over 94 percent of Americans, including a 31 million-person uninsured; costs $49 billion; and achieves almost $1 trillion in cost savings.

Just this week, a bipartisan group of more than 20 leading economists released a letter urging passage of meaningful health reform. The economists said our provisions to improve delivery system reform and slow the growth of health care costs “will reduce long-term deficits, improve the quality of care, and put the nation on a firm fiscal footing.”

The challenges facing our health care system are not new. They are old. But if we fail to act, they will surely get worse, meaning higher premiums, skyrocketing costs, and deeper instability for those Americans who have coverage.

Today, thanks to a lot of hard work from a lot of people, we are closer than ever to enacting solutions to these problems and getting a finished bill to President Obama’s desk as soon as possible.

Now is the time for us to set aside the childish politics that put us here. Now is the time to ignore the siren song of special interests. Now is the time for us to create a meaningful health care reform for working families and small businesses all across the United States.

Madam President, I yield the floor and look forward to hearing the remarks of my colleague from New Hampshire.

The PRESIDING OFFICER. The Senator from New Hampshire.

Mrs. SHAHEEN. Thank you very much, Madam President.

I rise to join my colleague, Senator BENNET from Colorado, to express my strong support for moving forward to consider the Patient Protection and Affordable Care Act.

My office has responded to thousands of letters and phone calls about health care since we began this debate. I have traveled all across my home State of New Hampshire, talked to small business owners, talked to families who are desperate for help and to health care providers who are frustrated with our current system. Time and time again, what we have heard is that our health care system is not working. Costs are too high. Access is too limited. The status quo is not sustainable.

Now is the time to act. To put it very simply, our health care system is too expensive for families, for workers, for business owners, and for our Nation’s economy. I think Senator BENNET laid out very clearly why, if we are going to be fiscally responsible, we have to address health care reform now. It is critical for the Senate to act.

I thank Majority Leader REID and Senators BAUCUS, DODD, and HARKIN, who have led the effort to bring for-

The Senators from New Hampshire, because it has been leading the way on some of this important research. What Dartmouth’s research shows us is that when patients are engaged in their treatment decisions, they will choose the less invasive and less costly procedures 40 percent of the time. So almost half of the time, we know patients, when they are involved, are going to choose the less costly procedures—by doing so, they are going to be happier about those treatment decisions. We know, based on this research, that the health care system can do better in so many cases for less and that we can recoup savings in our system.

One example of that, which I have worked hard on, along with Senator COLLINS from Maine, is something we call the Medicare Transitional Care Act. Experts estimate that we can save $5,000 per Medicare beneficiary if we can reduce costs of readmissions. That is what our work shows. Medicare costs can be reduced and we can offer better support and coordination of care to Medicare patients if we keep seniors who are discharged from the hospital from unnecessarily returning. We know the Medicare program is already the beneficiary. So what is this bill going to do? It is going to get readmitted within 90 days because we do not do a
good job of providing for that transition. If we add a benefit through Medi-
care that helps with that transition, we have a commonsense solution that will
improve the quality of health care for our seniors and save taxpayers money.
I am very pleased that this provision is included in the health care reform bill that
is before us now or that we hope will be before us soon.

We can also contain health care costs by improving access to lower cost
generic drugs. Again, that is something that the health care reform bill will
we are going to be considering. It gives people access to those lower cost ge-
neric drugs in a way that saves, generally, anywhere from 25 to 35 percent
for generic drugs. It also sets up a process
to give people access to lower cost
biologic drugs—something we do not
yet have, the ability to set up a process
to give people access to generic bio-
logic drugs. So that is going to be able to
save people money.

This is the kind of thing we hope to be able to work on will help Americans access
lower cost medications. It will save taxpayers money. This is our oppor-
tunity to improve the quality of care available to Americans and to control costs,
precisely. It is critical we achieve this for the citizens of New Hampshire and for all Americans. The
Patient Protection and Affordable Care
Act is a very important step forward. I
hope all my colleagues will, as we de-
bate this bill, look at the important
changes we are making and decide this
is our opportunity to get real, mean-
ingful health care reform done.

Thank you, and I yield the floor.

The PRESIDING OFFICER. The Sen-
ator from Missouri is recognized.

SEPTEMBER 11 TERRORISTS’
TRIALS

Mr. BOND. Madam President, faith
has written many painful chapters in
America’s history. Each is sharply en-
graved in our memories. Many involve
military conflict: the British burning
of Washington, the Civil War, Pearl
Harbor, Iwo Jima, Pork Chop Hill.

Others were singular acts of aggres-
sion, such as the bombing of the Okla-
oma City Federal Building, the assas-
sinations of Martin Luther King and
Presidents Lincoln, McKinley, and
Kennedy.

September 11, 2001, is the latest pain-
ful chapter in American history, one
that forever will be burned into our
memories as a day of horror unlike any
we have experienced before. The sheer
magnitude and deliberate evil of the
attacks that day defy comprehension.

Who among us will soon forget the wrenching
images of passenger planes used as missiles aimed at the World
Trade Center Towers and the Pentagon
or the people diving out of 70-story
windows to avoid being burned again,
and the heroic efforts of those passengers aboard Flight 93 as it headed
toward the Nation’s Capital? Who among us will forget the pictures and
the hopeful messages that sprang up around the area where the World Trade
Center once proudly stood as relatives searched in vain for loved ones?

Three thousand men and women per-
ished that day at the hands of terror-
ists who cared nothing for the innocent
dees they stole. As the towers fell, their
comrades and sympathizers, in-
cluding Khalid Shaikh Mohammed,
diabolically cheered the devastation.

It is therefore of 9/11 that
make last week’s decision by the
Obama Justice Department to give the
mastermind of these attacks and his
associates all the rights and benefits of
a civilian trial in New York City
unexplainable and compel me to rise to
voice my strong objection to that deci-
dion.

It is an insult to the memories of those who were brutally murdered on
September 11 that the perpetrator of
these cowardly acts will sit in a court-
room blocks away from Ground Zero
and reap the full benefits and protec-
tions of the U.S. Constitution. Even
worse than the insult to the victims
and their families is the dangerous
precipice the Obama Justice Depart-
ment has now crossed with this fool-
hardy decision. Earlier this year, the
Homeland Security Secretary signaled
an alarming change of perspective
about the nature of the enemy we face.
No longer would we call the acts of ter-
rorism what they are: acts of war. In-
stead, according to Secretary
Napolitano, the accepted terminology
for an attack such as 9/11 would now be a “mass-casualty event.” Apparently,
9/11 was no different than a forest fire
started by an arsonist.

This initial change in terminology was troubling enough, but trying
Khalid Shaikh Mohammed and his 9/11
associates in civilian Federal court
sends a loud and clear signal that this
administration is now comfortable re-
casting certain acts of terrorism as
simply what the Attorney General
calls “extraordinary crimes.” I have to
wonder if the Attorney General thinks
Pearl Harbor was an extraordinary
crime. In the logic of this administra-
tion, murdering 3,000 civilians, includ-
ing servicemembers at the Pentagon,
is an extraordinary crime, justifying trial
in a civilian court. Yet killing 17
servicemembers aboard the USS Cole is
an act of war or the murder of 13 service-
members at Fort Hood justifies contin-
ued proceedings before the military
omninary military commission—distinc-
tion makes no sense and shows a dis-
turbing lack of understanding of the
nature of this war.

It also creates a perverse incentive
for terrorists to attack civilians so
they may calms claims that they have
treasured constitutional protections. KSM
understood the benefits of these protections
when, as former CIA Director George
Tenet has said, KSM defiantly told CIA
interrogators after his capture: “I’ll
talk to your military and tell you to
New York and see my lawyer.” He was
counting on going to New York to get
the protections of our Constitution.

Words are simply words, but the
mentality that these words represent is
dangerously naïve. Whether it is called
a man-caused disaster or extraordinary
crime, refusing to treat the September
11 perpetrators as terrorists, deserving
of the protections of our military com-
m, is a dangerous throwback to the
pre-9/11 mentality that resulted in the
attack on the USS Cole, the bomb-
ings of our embassies, and the first
World Trade Center bombing.

Initially, I supported the concept of
prosecutorial discretion and the right of
the executive branch to bring crimi-
 nal actions against perpetrators as sup-
ported by the facts. But in this in-
stance, this discretion must give way
to the larger national security inter-
est of our country. In spite of the stat-
ed intention of KSM to plead guilty in
the military commission, the Attorney
General has asserted he believes there is
a greater chance of success against these 9/11 coconspirators in civilian
prosecution. This belief—this doctrine—
do not justify the enhanced risks to
our security and the dangerous prede-
cent for the treatment of future terror-
ists this trial will bring.

That this case will establish a very
bad precedent was made clear by the
Attorney General in his testimony be-
fore the Senate Judiciary Committee,
when he summarily dismissed concerns
that the decision to bring 9/11 co-
spirators into Federal court would
precipitate community interrogation of Osama bin Laden if he were captured. The
Attorney General refused to say whether bin
Laden would be given Miranda warn-
ings upon capture and claimed “the case
against him is so overwhelming”
that there would be no need to rely on
any statements he might make after
capture. Mr. Holder called the concerns
about not being able to interrogate bin
Laden a “red herring.” Well, unfortu-
nately, the Attorney General’s testi-
mony shows a complete lack of under-
standing that the purpose of intel-
ligence interrogations is to stop
planned attacks and to take down ter-
rorist networks, not to elicit confes-
sions for use in a criminal trial.

It is beyond troubling that the Attor-
ney General, as the head of the Depart-
ment of Justice, the Justice Depart-
ment’s FBI National Security Divi-
sion—the very people charged with pre-
teering terrorist operations whose
activities disrupted in New York, Illinois, and
North Carolina, seem to have no inter-
est in obtaining valuable intelligence from bin Laden. As the leader of al-
Qaida, bin Laden clearly has consid-
erable knowledge of its network, its
members, its methods, and its poten-
tial plots to kill more Americans. So
what the Attorney General calls a red
herring, I call a red flag.

Some have hailed the administra-
tion’s decision as an intelligence
and punitive system for the world, but
the Attorney General has confirmed
that in the event KSM or one of his as-
ociates is acquitted, he will still be
detained indefinitely. Are you sure, Mr. Attorney General, that a court will not order him released?

This begs the question: Why should we incur the time, expense, and risk our national security on a show trial if we are detaining terrorist suspects for years, nor the facts and perceptions that may sway any one of 12 jurors who will decide KSM's fate. A conviction will be expected, but there can be no guarantees.

Make no mistake, America is still at war. The war on terror is real. It will not go away just by calling it another name. We cannot afford to bury our heads in the sand. While Khalid Shaikh Mohammed may ultimately be convicted, our success in the war against terrorism was still very real. For the men and women massacred in cold blood at Fort Hood, the ongoing threat of terrorism is all too real.

The Obama administration is standing up to domestic terrorism. It is either persist in downplaying the reality that we are at war with terrorists or it can affirm that its top priority is to keep Americans safe by winning this war on terror.

Madam President, success in this war on terror cannot simply be defined as getting a guilty verdict against KSM in a civilian federal court. If the Department of Justice jeopardizes our intelligence sources and methods, it is not clear what price we pay. The process would not be jeopardized. While changes have been made over the years to the process itself in light of Supreme Court decisions, the general framework and principles remain solid. This process isn’t new to this administration.

This process isn’t new to this administration either. The administration is not only using this process, the Attorney General announced that the USS Cole bomber will still be tried under the commission. They worked with Congress to make the changes to it.

Yet in the case of the 9/11 conspirators, the administration has chosen to reject the tried and true method of prosecuting enemy combatants in a venue where intelligence sources and methods are unlikely to be compromised in favor of circles that will make the trial of Zacarias Moussaoui, with its endless motions and Moussaoui’s challenge of a duel to former Attorney General Ashcroft, seem like a mundane proceeding.

This is an unnecessarily dangerous gamble. While the decision to take this gamble with our national security is clearly a matter for the executive, the administration has found a willing ally in many of my colleagues in Congress. Earlier this month, I joined 44 other Senators, from both sides of the aisle, in supporting an amendment to prohibit taxpayer funds from being used to prosecute in a civilian court the 9/11 perpetrators. Unfortunately, we were outvoted. The amendment didn’t pass.

I encourage my colleagues to rethink their opposition. When the appropriate time comes, I hope they will reaffirm that our national security interests must have priority over politically correct prosecutions.

We are rightfully a different nation today than it was before September 11. We were attacked in a way and at a magnitude that we hope never to experience again. But we simply cannot rely on hope alone. Following these terrorist attacks, we took critical steps to try to ensure we are never attacked like this again. We made sure that we gave our intelligence professionals the tools they needed to fight terrorists, not just criminals. We gave them the tools they needed to fight a war that keeps America safe.

We must always remember the lessons of September 11. We owe it to the victims of these and other terrorist attacks to keep our Nation safe. I call on the President from this floor to reverse the disastrous decision of the former Attorney General and reafirm his commitment to our national security and to winning this war against terrorism.

I yield the floor.

The PRESIDENT PRO Tempore. The majority leader is recognized.

Mr. REID. Madam President, I apologize to the Republican leader. I was detained in my office talking to another Senator, so I apologize for not being here and his having to wait.

UNANIMOUS CONSENT AGREEMENT—H.R. 3590

Mr. REID. Madam President, I ask unanimous consent that, on November 20, at 10 a.m., the Senate proceed to a period of debate on the motion to proceed to H.R. 3590, until 11 p.m., with the time controlled in alternating 1-hour blocks, with the majority controlling the first hour; and at 10 p.m., Friday, there be 30-minute blocks until 11 p.m., with the majority controlling the first 30 minutes; and at 10 p.m., Saturday, November 21, at 10 a.m., the Senate continue with controlled debate in alternating blocks until 6 p.m., with the majority controlling the first hour block; that at 6 p.m., the majority control the time until 6:30 p.m., the Republicans then control 6:30 to 7:15 p.m., the majority control 7:15 p.m. to 7:30 p.m., the Republican leader controls 7:30 to 7:45 p.m., and the majority leader controls 7:45 to 8 p.m.; that at 8 p.m., the Senate proceed to vote on the motion to invoke cloture on the motion to proceed to H.R. 3590; that if cloture is invoked on the motion, then all post cloture time be yielded back, the time to be saved; and the motion to reconsider be laid upon the table; that after the bill is reported, the majority leader be recognized to
call up his amendment and that it be reported by number only.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

SERVICE MEMBERS HOME OWNERSHIP TAX ACT OF 2009—MOTION TO PROCEED

CLOTURE MOTION

Mr. REID. Madam President, I move to proceed to Calendar No. 175, H.R. 3590, and I send a cloture motion to the desk.

The PRESIDING OFFICER. The cloture motion having been presented under rule XXII, the Chair directs the clerk to read the motion.

The bill clerk read as follows:

CLOTURE MOTION

We, the undersigned Senators, in accordance with the provisions of rule XXII of the Standing Rules of the Senate, hereby move to bring to a close the debate on the motion to proceed to Calendar No. 175, H.R. 3590, Harry Reid, Tom Harkin, Jack Reed, Edward E. Kaufman, Jeff Merkley, Roland W. Burris, Daniel K. Akaka, Patty Murray, Richard Durbin, Sherrod Brown, Barbara Boxer, Frank R. Lautenberg, Jeanne Shaheen, Sheldon Whitehouse, Bill Nelson, Mark Udall, Benjamin L. Cardin, Christopher J. Dodd, Patty Murray.

Mr. REID. I ask that the mandatory quorum required under rule XXII be waived.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. REID. I thank the Chair.

The PRESIDING OFFICER. The Senator from Minnesota is recognized.

Mr. FRANKEN. Madam President, I ask unanimous consent that I be allowed to speak in morning business for up to 5 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

COBRA SUBSIDY EXTENSION AND ENHANCEMENT ACT

Mr. FRANKEN. Madam President, I rise today to urge my colleagues to support S. 2730, the COBRA Subsidy Extension and Enhancement Act.

As you may know, COBRA allows jobless workers to keep their health care as they look for new work. The Recovery Act included a COBRA subsidy through 2010, but if we fail to act, millions of Americans currently looking for work will be faced with a further unbearable burden—the tripling of their COBRA payments.

I am very pleased with the Senate Patient Protection and Affordable Care Act that was released yesterday. This bill will help bring down health care costs for families and the Federal Government. We will invest in prevention and provide incentives to doctors to provide high-quality health care. I commend Leader Reid, Chairman Harkin, Chairman Baucus, and Chairman Dodd for moving us one critical step closer to secure, affordable health care for all Americans. But while health care reform will bring long-term relief, the proposed COBRA extension will help us bridge the gap before health care reform is fully implemented.

Take the situation of one of my constituents, Gregory, from Lakeville, MN, southeast of the Twin Cities. Gregory has built a professional career in the printing industry, the same industry my dad was in. He was a printing salesman for 30 years. The printing industry has been especially hard hit by our current recession. Gregory’s wife depends on him for health insurance. She has rheumatoid arthritis. My mom had rheumatoid arthritis. Gregory also has two daughters in school.

Gregory was laid off this March and has been tirelessly looking for a job ever since. But there aren’t any jobs to be found. Now he has accepted that he may have to change fields, but he is 57 years old. At 57 that isn’t easy. Unless Congress passes a COBRA extension, his premiums will nearly triple, going from $350 a month to $940 a month. In today’s dismal economy, who has $940 each month to spend on health care insurance, especially if you don’t have a job?

Gregory has explored the option of a private insurance plan, but his wife’s preexisting rheumatoid arthritis makes private plans an impossibility. Gregory’s family is not alone in this plight. CBO estimates that 7 million workers and their families have used the COBRA subsidies in 2009. That includes thousands and thousands of Minnesotans. The expiration of the subsidy will make premiums so expensive that many families will be forced to drop their coverage, adding further to the number of uninsured Americans. Now is the time to put another burden on struggling families.

The COBRA Subsidy Extension and Enhancement Act will provide relief to families by extending the COBRA subsidy another 6 months, through June of 2010. By that time, our economy will have made significant progress in job creation, and many Americans will be back on their feet. This bill will also include an increase in the subsidy—from 65 percent to 75 percent—allowing more families to retain coverage.

During this recession, the last thing Congress should do is pull the plug on benefits before folks have had a chance to get back on their feet. I know my colleagues Senators Brown and Casey share the same goal of passing meaningful health care reform this year, but they also know the importance of providing a stopgap measure to deliver relief to families who are struggling in the current downturn. I thank them for their leadership on these critical issues.

I urge my colleagues to swiftly enact the COBRA Subsidy Extension and Enhancement Act and allow more families to maintain health care insurance coverage as they look for work.

I yield the floor.

The PRESIDING OFFICER. The Senator from Mississippi is recognized.

Mr. COCHRAN. Madam President, in the coming weeks and months, the Senate is scheduled to complete action on bills that will have a profound impact on Federal spending for many years to come. I rise to express my concerns about the manner in which new spending is being proposed in that legislation.

Congress has sent 5 of the 12 annual appropriations bills to the President this year. The Senate has not yet acted upon the three remaining bills under our jurisdiction.

Last year, Congress completely abandoned the appropriations process. The President had to act, but only a few bills were acted upon by the Senate before all of the bills but one were bundled into an omnibus bill and sent to the President.

Thus far this year, we have not been able to complete action on all 12 appropriations bills, but we have made significant progress. The Senate has debated a stand-alone Agriculture appropriations bill and an Interior appropriations bill for the first time in 4 years. Ideally, all of the spending bills should be subjected to the scrutiny of the full Senate every year. This year, there have been hearings in each subcommittee, and the bills have been subjected to subcommittee and full committee markup.

We have tried to get the bills to the floor individually so all Senators have an opportunity to offer amendments, and so we can avoid the necessity of grouping the bills into an omnibus bill.

The chairman, who is the distinguished Senator from Hawaii, Mr. Inouye, deserves the credit for these improvements. All Senators on the committee have cooperated, though.

Despite the many difficulties associated with enacting the appropriations bills, the process compels us to hear testimony, analyze programs, and consider funding needs and priorities on an annual basis. It is not always a smooth or easy process, but it has the benefit of compelling us to continually re-evaluate the level of Federal spending. That is not the case when we create long-term or permanent mandatory spending programs.

I don’t mean to criticize the oversight of the authorizing committees. Many of them do excellent work in this regard, holding agencies and funding recipients accountable for their management decisions. But once a funding stream is made mandatory, it is difficult to reduce spending or to use the leverage of future funding to motivate more efficient management of Federal programs or activities.
One of the justifications often cited for creating mandatory spending programs is that the funding recipients need predictability to properly and efficiently manage programs. While there may be some truth to this, it is not a sufficient reason to make a program mandatory or to change an existing program from discretionary to mandatory.

If increased predictability is the goal, Congress should make greater efforts to get the annual appropriations bills finished on time and in a responsible and in an open and orderly fashion that allows scrutiny of the proposed spending.

Failure to process the appropriations bills in this manner has the effect of driving interest groups to seek the predictability of long-term mandatory funding streams. In effect, we create a situation whereby Congress must take proactive steps to reduce or eliminate spending as opposed to proactive steps to continue or expand programs.

As a general matter, we should be very careful about moving programs in that direction, in my opinion. As I look at the major legislation that Congress is slated to consider over the coming months, I am particularly concerned. Of most immediate concern is the health care bill on which we will soon begin debate.

The bill reported by the Senate Finance Committee contains new programs. I want to make an important point about whether these programs should be funded or not funded through the annual appropriations process. There are mandatory programs for maternal, infant, and early childhood home visitation and for personal responsibility education for adulthood training. There are grants for school-based health centers, a demonstration program for emergency psychiatric care, and a demonstration program to address the health profession’s workforce needs.

A previously authorized childhood obesity program is directly funded with a mandatory appropriation. Many of these programs are funded for only a few years, just enough time to get funding recipients invested in the program, after which expectations will be overwhelming that the programs be continued with annual appropriations.

As ranking member on the Labor, Health and Human Services Subcommittee, I might be inclined to support funding some of them, but beginning new programs with short-term, mandatory funding is a recipe for trouble. It results in hiding the long-term costs of these programs and provides no opportunity upfront to consider trade-offs between the new programs and existing programs.

The health care bill reported by the HELP Committee includes a new prevention and public health fund to support an ‘expanded and sustained national investment’ in prevention and public health programs to improve health and help restrain the rate of growth in private and public sector health care costs.’ That is a quote from the bill. The bill appropriates $2 billion for this purpose in fiscal year 2010 alone and increases that amount to $10 billion by fiscal year 2014 and thereafter.

This has long been a priority of the Senator from Iowa, Mr. HARKIN. To the committee’s credit, the bill provides some latitude for the Appropriations Committee to allocate funds among various prevention and wellness programs in the outyears.

At its core, however, this provision implies that we know today what the appropriate Federal investment for wellness programs will be 10 or 20 years from now. I just don’t think that is plausible. If prevention and wellness programs are that important, let’s call up the Labor, Health and Human Services appropriations bill and either increase the size of the bill or reallocate money within the bill to support wellness programs. When the fiscal year 2011 appropriations process begins, let’s analyze how those programs are working and consider, once again, the appropriate funding levels for the coming year.

Beyond the health care bill, there is legislation to address global climate change. Here, again, we face the prospect of massive new annual Federal expenditures being established on a mandatory basis, effectively being put on autopilot right from the beginning. While the real value of the carbon allowances that would be auctioned under some climate bills, it is clear that tens of billions of dollars from such auctions would be plowed directly back into an array of programs administered by Federal, State, and local government agencies.

Some of the programs have a more obvious relationship to climate change than others. Just to list a few, the Senate-reported bill directly funds clean vehicle technology, building retrofits, advanced energy research, nuclear worker training, coastal preservation, and Federal land acquisition.

Many programs that would be funded by this bill are identical or similar to programs already funded in annual appropriations bills. Others are entirely new.

Are we truly confident in the year 2016 it will be prudent to spend 4.3 percent of an unknowable amount of auction revenues on international deforestation efforts? Are we sure, that in the year 2030 we should be spending 74 percent of auction proceeds on worker assistance programs?

Congress should protect its ability to reconsider support or opposition to such spending annually, or at least periodically, based on program performance and our current national interests.

What about funding of Federal land acquisition? I have supported some Federal land acquisition in my State of Mississippi, sometimes to incorporate important resources into our National Park System, sometimes to preserve sensitive habitats by including them in our national wildlife refuge system or in our national forests. I have had other Senators request specifically that we not approve the Federal acquisition of a particular piece of property. This has been a sensitive issue for our western colleagues, particularly in whose States Federal land ownership is already extensive. Yet in the climate bill, we are being asked to allocate funding to the Commerce branch on an annual basis for unspecified Federal land acquisition projects, all with no apparent mechanism for congressional oversight.

Are any Senators really comfortable with that arrangement? This is just one example of why Congress should consider programs on an annual basis through an open process rather than putting programs on autopilot and directly funding some of them, but beginning new mandatory programs in the outyears.

Many programs that would be funded by the House-passed bill establishes a number of new mandatory education programs and expands several existing programs with mandatory funding streams. The Congressional Budget Office estimates the House-passed bill would reduce mandatory spending by $87 billion over the next decade. But the House bill directly spends all but $8 billion of that amount on new and expanded programs. It directly funds a new college access and completion innovation fund. It establishes mandatory funding streams for school modernization, renovation, and repair, including a program of supplemental grants for States and institutions in the Gulf that provides mandatory programs for early childhood education and for reforming community colleges and improving training for workforce development.

In many cases, these are new programs. In some cases, the mandatory amounts are meant to supplement funding currently provided through annual appropriations.

Regardless of the merits of these programs, the fact remains that we are faced with a debt problem of huge proportions. We have now closed the books on fiscal year 2009, finishing the year with a budget deficit of $1.4 trillion. We began fiscal year 2010 with a deficit of $420 billion. Our National debt has hit $12 trillion, and soon Congress will have to act to raise the Federal debt ceiling again.

President Obama’s own budget, optimistic in many respects, forecasts that our national debt will be rising to 66 percent of the gross domestic product by 2013. The Congressional Budget Office forecasts debt reaching 87 percent
of GDP in 2020 and increasing thereafter to even more alarming levels.

Given this set of facts, is it responsible to enact a bill that is expected to produce—not guaranteed to produce but expected to produce—a savings of $577 billion in mandatory spending but then to force legislation that spends all but $8 billion of that anticipated savings on new programs or expansions of existing programs that could just as well be achieved through the annual appropriations process?

It is responsible to advance a climate bill that spends tens of billions of dollars on new mandatory programs and to allocate funding among those programs for decades into the future when we have no ability to judge whether those programs are needed or effective or what different programs might be necessary depending on how climate legislation would affect our economy, our workforce, and our environment?

Can we afford to enact a health care bill that is new costly mandatory programs but short on cost savings that we all know must be found within our health care system?

Certainly, there are situations where mandatory funding is an appropriate mechanism to deliver government services. In cases where our goal is to provide a service to a certain group of eligible people, regardless of how many people may be eligible in a given year, a mandatory appropriation may be the most efficient means of achieving that goal.

Given our Nation’s fiscal situation, however, it seems to me we should strongly favor a procedure that requires Congress to consider programmatic spending every year. This is the very principle stated in paragraph 13 of rule XXVI of the Standing Rules of the Senate. This is not a question of which committee has the power over the purse. It is a question of whether Congress will retain the power over the purse and deliberately exercise it.

Every year in appropriations bills, programs are terminated, reduced, or expanded based on performance and the availability of resources, pursuant to the budget resolution. Interest groups and program beneficiaries are required to give us their views annually. The competition for available dollars is intense. But so what? Whether it is health care, climate change, education, or other legislation, Congress should be very careful to deliver government services because it fundamentally weakens our ability to control Federal spending at a time when we greatly need to exercise that control.

I hope my colleagues will keep this in mind as we proceed with the business before us.

The PRESIDING OFFICER (Mr. WHITEHOUSE). The Senator from Maryland is recognized.

Mr. CARDIN. Mr. President, shortly we will have an opportunity to vote on moving forward and considering health care reform in this country. I thank the majority leader, Senator REID, for putting together the bill that came out of our two committees that accomplishes what I think are the three goals we need to accomplish in health care reform. I have been asked by the people of Maryland whether I would support a particular bill, and I find that the reader for me to vote for a bill, it has to do three things: First, it needs to bring down the cost of health care in America; second, it needs to provide an affordable quality insurance option to every American; and third, that must be done in a fiscally responsible way.

The bill Senator REID is bringing forward accomplishes those three goals. First, it brings down the cost of health care in America by about $1 trillion. It does it by investing in prevention and healthy lifestyles; by cracking down on fraud, waste, and abuse; and by eliminating unnecessary administrative costs in our health care system. That is the way we should bring down health care costs in America. That will improve quality but bring down costs.

Second, this bill allows every American to have access to affordable health insurance and health care. The Congressional Budget Office estimates the net cost of this bill will be uninsured in America by 31 million. We will be able to get 98 percent of Americans who are in this country legally, citizens, covered by health insurance as a result of this legislation.

Third, this bill moves forward in a fiscally responsible way by not only staying within our budget but by actually reducing our budget deficit by $127 billion with no new tax burdens on middle-income families.

I am particularly pleased this bill will help middle-income families in America. Mr. President, I know you have received letters from your constituents. I have received letters from my constituents that tell us the status quo is unacceptable for any of us. Under the budget resolution process by which private insurance companies would be prohibited, and the Cathcarts and should not be acceptable for any of us. Under the budget resolution, Congress should be very careful to deliver government services because it fundamentally weakens our ability to control Federal spending at a time when we greatly need to exercise that control.

I hope my colleagues will keep this in mind as we proceed with the business before us.

The PRESIDING OFFICER (Mr. WHITEHOUSE). The Senator from Maryland is recognized.

Mr. CARDIN. Mr. President, shortly we will have an opportunity to vote on moving forward and considering health care reform in this country. I thank
That is why the bill the leader is bringing forward, that will cover 98 percent of Americans, is going to help middle-income families by eliminating that hidden tax of $1,100 per family in Maryland and around the country.

Health care costs are growing three times faster than the wages that are growing in America. Inaction should not be an option.

For small businesses the situation is very dire. They are spending 20 percent more on health care than the larger company that does the same business that is larger. Just as stressful, they cannot predict what the annual premium increase is going to be. How can you run a business without knowing what your costs are going to be from 1 year to another? For the sake of small businesses we need to move forward with health care reform.

A lot of families in Maryland depend upon Medicare; a lot of middle-income families in Maryland depend upon Medicare. This bill will strengthen Medicare by dealing with the underlying costs of health care, by getting that under control. At the same time we protect Medicare for the future, we provide additional benefits for our seniors by starting to close the doughnut hole, getting prescription drug costs under control, and providing preventive care for our seniors. This legislation will help middle-income families by dealing with insurance reform and eliminating preexisting conditions. It will provide those pools for the more choice for middle-income families.

This legislation will help workers who work for small companies. It will help those people in our community who have preexisting conditions. It will help those people in our community who are changing jobs. It will help those in our community who depend upon Medicare. This legislation is absolutely critical for middle-income families in America.

The status quo is unacceptable. We need to act, and we are going to have a chance to do that when we vote Saturday on proceeding with health care reform. I urge my colleagues to move forward on this vital legislation for America.

I yield the floor.

The PRESIDING OFFICER. The distinguished Senator from Utah is recognized.

Mr. BENNETT. Mr. President, I enjoyed listening to my colleague from Maryland. He says to us repeatedly the status quo is not acceptable. I agree with that. I would point out to him that the bill that has been presented to us by the majority leader guarantees the status will remain “quo” until 2014. This bill delays implementation until 2014. For 4 years the status will remain “quo” on key provisions.

Mr. CARDN. Will my colleague yield on that point?

Mr. BENNETT. I am happy to yield.

Mr. CARDN. Let me point out that much of the insurance reform takes effect immediately. The preexisting conditions are dealt with immediately. The larger pools for those who can’t find health coverage, that is done and implemented immediately.

Mr. BENNETT. I understand, but the key provisions of the bill that cost significantly and are postponed until 2014. Why? Because unless you make that postponement you cannot get the score down to the point where it is in the majority leader’s bill.

The challenge is that the real cost of health care is substantially more than this bill demonstrates as it comes out of the Congressional Budget Office. Why? Because the Congressional Budget Office is required by law to give costs over a 10-year period. If this whole thing started at the time the bill was passed and ran for the whole 10 years, the cost would be so high that it could not be offset with the programs that have been put in the bill. So the easy way to save costs and bring it down below the level that is acceptable is to delay the implementation until 2014.

We saw that in the Finance Committee. The Baucus bill moved the date of implementation from January 1, 2013, to July 1, 2013, to save money. Now the Senate bill moved it to January 1, 2014, to January 1, 2014, an entire year of additional “savings.”

These are not savings at all. These are simply a delay in the implementation and therefore a delay in the expenditures.

I want to move to the point the Senator from Mississippi was making with respect to the impact of this on the national debt and the national deficit. The last time we had a budget from President Bush, the last Bush budget said the total expenditures would be $3.1 trillion.

President Obama’s budget called for expenditures of $3.6 trillion or $0.5 trillion more. OK, $0.5 trillion more, you would assume, therefore, that the deficit that would occur would be roughly $0.5 trillion more than the Bush deficit. But the last deficit of the Bush administration, before the financial crisis hit us, was $1.16 trillion. That is $0.1 trillion of the $3.1 trillion. And the first deficit of the Obama administration is $1.4 trillion.

You say: Wait a minute. Those numbers do not add up. The reason they do not add up is, we can control how much we spend, but we cannot control how much we take in. How much we take in is a function of the economy.

Let’s go back to the budget that was submitted and passed by the Obama administration and passed on the floor of the Senate by the Democratic majority. It projected $2.2 trillion in revenue, and it projected $2.2 trillion in entitlement spending, mandatory spending. That meant that everything else in government had to be borrowed. Money for the Defense Department had to be borrowed, the State Department, all of our embassies overseas, all of that money had to be borrowed. The money for transportation, for the Federal Aviation Administration had to be borrowed. The money for national parks had to be borrowed. The money for education had to be borrowed.

It wasn’t that the expenditures went up an extra $0.5 trillion to get a $1.4 trillion savings. It was that the revenues went down. Yes, the expenditures did go up. The expenditures under the Obama budget went up roughly $0.3 trillion from the expenditures under the Bush budget. But the big problem was, the revenues went down at the same time.

The cautionary tale that comes out of this is, again, we can control how much we spend, but we cannot control how much we get in. That is a function of the economy. Money does not come from the budget; money comes from the economy. When the economy is weak, as it is now, we are going to have deficits, no matter how big an effort we make to try to avoid them, because the money simply does not come in.

The reason I make that point is because, back again to the numbers that we realized when we were debating the budget, the money coming in was $2.2 trillion and the money already committed was $1 trillion more. The difference was that the Congress did not deal with in the appropriations process was $2.2 trillion. What we will do, if we pass the bill the majority leader has introduced or will introduce, is to increase the amount of mandatory spending, increase the commitment of the Federal Government to make expenditures in the health care area that will be beyond the reach of the Appropriations Committee, that will be going out whether or not we have the money coming in to pay for them.

I know the score out of CBO says this will save money for the Federal Government, but let’s get into the details of what the CBO had to say to see how much it would save and see why it would save.

The CBO says, about the longer term calculations with respect to this bill:

These longer-term calculations assume that the provisions are enacted and remain unchanged throughout the next two decades, which is often not the case for major legislation.

I think that is one of the understatementst of the year. Major legislation does not often go unchanged for two decades. Congress will add goodies. Congress will delay some of the tax provisions. We see that every year with respect to the legislation known around here as the doc fix. It is in the law right now that every year we cut reimbursements to doctors under Medicare, and every year the Congress comes in and says: We won’t do it this year. The doc fix comes in and says: We will change this earlier situation. That means any score that depends on our not passing a doc fix is going to be wrong. CBO says that.

Again, these longer-term calculations assume that the provisions are enacted and remain unchanged throughout the next two decades.
We cannot produce that kind of money on the revenue side because we cannot really control the amount of revenue that comes in. The amount of revenue that comes in is a function of the economy.

On the other hand, where are we this year? Mr. President, $2.2 trillion in revenue, substantially below the amount of revenue that came in in the Bush administration. It is not Bush's fault that there was more or less. It was the economic downturn. And if we think in this body we can repeal the business cycle and see there will be no downturns in the future, we are really kidding ourselves. There will be downturns, and there we will be, with the commitment in place, the increase in the Federal budgetary commitment to health care, without the revenue to pay for it.

This is CBO again:

The short-term budgetary impact could be quite different if key provisions of the bill were ultimately changed or not fully implemented. If those changes arose from future legislation, CBO would estimate their costs when that legislation is being considered by the Congress.

In other words: We will make no attempt to guess what is going to happen in the future, but we can tell you that an economic downturn in the future is going to make all of our predictions wrong. That is the logical thing for them to say. It is the prudent thing for them to say, and it is the accurate thing for them to say.

There are some things about this bill that I don’t like. I am convinced it will increase premiums for those who currently have health insurance. There is no way it can produce the kinds of results my friend from Maryland talked about of covering 30 million more people and cutting costs for everybody in Middle America without costing a lot more money someplace else. One of those places is going to be either in your tax responsibilities or in increased premiums or in State.

We all know how the Governors feel about this proposal. The Governors have said this proposal will bankrupt us by the rolling of Medicaid costs onto the States—not Republican Governors, it is Democratic Governors who have come forward and said: We can’t handle this. So there are lots of things about this bill I don’t like.

But I believe the score that has been put by the prominent public accountant is not accusing CBO of doing anything wrong. I am accusing those who wrote the bill of putting in provisions so that we will delay this implementation there, we will call for this tax here and the score that goes there and so on. And it is true, when we find all of that information into the computer and then say: O mighty computer, none of this will change, what is the number, the computer gives you a number, but it is a number based on assumptions that are based on smoke and mirrors.

There is an old saying: Where there is smoke, there is fire. This bill has a lot of smoke in it. And, in my opinion, it is the American people who are going to get burned.

I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

The PRESIDING OFFICER. The Senator from Pennsylvania.

Mr. SPECTER, Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

PATIENT PROTECTION AND AFFORDABLE CARE ACT

Mr. SPECTER, Mr. President, I have sought recognition to comment briefly on the Patient Protection and Affordable Care Act, which was disclosed late yesterday by our distinguished majority leader, Senator REID, to whom we all owe a debt of gratitude for the extraordinary work he did in putting together this very complex legislative proposal. Also, compliments are due to Senator BAUCUS, who chairs the Finance Committee, and Senator DODD, who carried on the work of Senator Kennedy on the Health, Education, Labor and Pension bill. The bill provides for gross spending of $979 billion over a 10-year period, under the $1 trillion dollar mark. The coverage allocation is $848 billion. There are gross savings of $1.309 billion, and the deficit impact is to have a reduction of some $130 billion over the 10-year period. In the second 10-year period, the projection for savings is substantially greater. There will be millions of Americans covered who do not now have health coverage, so over 94 percent of all legal residents of all ages will be covered.

We are now digesting this very complex piece of legislation. The majority leader has scheduled time here for Saturday at 8 p.m. It is my hope and, candidly, my expectation that we will have the 60 votes to proceed for the consideration of this bill.

It is my view that inaction is not an option; that there are too many people not covered by health insurance or who are underinsured. The cost of health coverage is escalating at such a tremendous rate. It is having a great impact especially on small businesses. A President's prominent public accountant noted that rates for small business were being dramatically increased. Senator HARKIN scheduled a hearing in the Health, Education, Labor, and Pension Committee. One of my constituents from Lancaster came in to testify that his premiums were rising by 128 percent. So I believe that inaction is not an option.

We have had many declarations of positions, and in the Senate, where you need 60 votes to move ahead, every one of these votes is indispensable. Only one Republican, Senator SNOWE in the Finance Committee, supported the Finance Committee bill, so there was no
FORECLOSURES

Mr. SPECTER. Mr. President, while I have the floor, I wish to briefly address one other subject. I know my colleague is on the floor waiting for an opportunity to speak. This relates to a plan which is being carried on in the city of Philadelphia to stop foreclosures. We have seen a tremendous problem across America with the housing bubble, with so many people being in houses they could not afford and so many foreclosures. The Philadelphia program received front-page attention in the New York Times just yesterday as a model program. I call the Philadelphia program in the attention of my colleagues and to anyone who may be watching CSPAN2, a program which is a model and which ought to be followed in other jurisdictions.

In March of 2008, the Philadelphia City Council approved a resolution called the Residential Mortgage Foreclosure Diversion Pilot Program. Following the council resolution, Philadelphia’s civil court adopted rules that no owner-occupied house could be foreclosed on or sold at sheriff’s sale before a mandatory conciliation conference between the borrower and lender aimed at finding a workable compromise. This Philadelphia program has emerged as a model, enabling hundreds of troubled home buyers to retain their homes.

In October of last year, a little more than a year ago, Senator CASEY and I held field hearings in Philadelphia and Pittsburgh to explore ways to keep borrowers in their homes using the successful Philadelphia program. I ask unanimous consent that at the conclusion of these remarks, a copy of the New York Times article be printed in full in the RECORD which details the Philadelphia program and is a suggestion for other cities as to how to follow that.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

[From the New York Times, Nov. 18, 2009]

PHILADELPHIA GIVES HOMEOWNERS A WAY TO STAY PUT

(By Peter S. Goodman)

Philadelphia—Christopher Hall stepped tentatively through the entranceway of City Hall Courthouse 676 to find among the dozens of others confronting foreclosure purgatory. His hopes all but extinguished, he fully expected the morning to end with a final indignity: a room sign over the door directing him to his house—his grandfather’s two-story row house; the only house in which he had ever lived; the house where he had raised three children.

“This is devastating,” he said last month as he sat in the gallery awaiting his hearing. “This is my childhood home. I grew up there. My mother passed away there. My grandfather passed away there. All of my memories are there.”

A union roofer, Mr. Hall, 42, had not worked since August 2008, when the contractor that employed him as a foreman went broke and laid off more than 40 people. He had not made a mortgage payment in more than a year, and his lender, Bank of America, was threatening to auction off his house through the sheriffs office.

In most American cities that probably would have been the end of the story: another home turned into distressed bank inventory by the national foreclosure crisis. But in Philadelphia, which began exploring last year to try to keep people in their homes, Mr. Hall entered the courtroom with a reasonable chance of hanging on.

Under the rules adopted by Philadelphia’s primary civil court, no owner-occupied house may be foreclosed on and sold by the sheriffs office before a “conciliation conference,” a face-to-face meeting between the homeowner and the lender aimed at striking a workable compromise. Every homeowner facing a default filing is furnished with counseling, and sometimes legal representation.

So, as Mr. Hall stepped into the ornate courtroom just after 9 o’clock, he was swiftly provided with a volunteer lawyer, Kristine A. Phillips. She huddled briefly with a lawyer for Bank of America and returned with a useful promise. The bank would leave him alone for six more weeks while his housing counselor prosecuted modifications in an attempt to lower his payments permanently.

“You’ve got more time,” Ms. Phillips told him. “We’ll get this all worked out.”

“Thank you so much,” Mr. Hall said softly, his body shaking with pent-up anxiety now tinged with relief. “It’s a lot of weight off my shoulders.”

In a nation confronting a still-gathering crisis of foreclosure, Philadelphia’s program has emerged as a model that has enabled hundreds of troubled borrowers to retain their homes. Other cities, from Pittsburgh to Chicago to Louisville, have examined the program and adopted its efforts.

“It brings the mortgage holder and the lender to the table,” said City Councilor John M. Tobin Jr. of Boston, who is planning to introduce legislation to enact a program in his city modeled on Philadelphia’s. “When people are face to face, it can be pretty disarming.”

When homeowners in Philadelphia receive legal default notices from their mortgage companies, the court system schedules a conciliation hearing. Canvassers working for the program visit foreclosed homeowners, distributing fliers that inform them of their rights to a conference, and urging them to call a hot line that can direct them to free legal advice.

“You can feel a certain sense of relief from their just being able to speak to someone about the program,” said Anna Hargrove, who works as a canvasser in West Philadelphia.

Every Thursday morning, the courtroom in sixth floor of the City Hall Courthouse’s 676 and 677 rooms is given over to the conciliation conferences. It fills up with volunteer lawyers in jogging shoes, who are representing homeowners; nonprofit organizations working for mortgage companies; and all variety of delinquent borrowers—elderly citizens leaning on canes, construction workers in overalls, parents with bored children in tow. The lawyers exchange preliminary settlement terms, while the homeowners fill out papers and wait.

In some cases, deals are struck that lower monthly payments for borrowers and allow them to retain their homes. When a homeowner cannot afford the home even at modified terms, the program helps to precipitate a graceful exit, in which the borrower accepts cash for vacating the property or signs over the deed in lieu of further payment.

Right to Mediation

The Philadelphia program forces an outcome by bringing together the principal players in one room. If the mortgage company proves intractable, the homeowner has the right to request mediation in front of a volunteer lawyer serving as a provisional judge, who relays recommendations to the program’s supervising judge. If the judge finds that the mortgage company is not acting in good faith, she can bring the proceedings to a halt by denying permission for a sheriffs sale.

While data is scant, a legal aid group, PHLForeclosures/Volunteer Program, has complete information on 61 of the 309 cases it has resolved since October 2008 through the anti-foreclosure program.

Nine resulted in sheriff’s sales, while 35 ended with loan modifications that lowered payments, the group says. The remaining 21 cases were divided among bankruptcies, loan forbearance and repayment arrangements, graceful exits and straightforward sales.

Some suggest the city’s program is plagued by the same basic defect as the Obama rescue plan: Nearly all the loans that have been modified have been altered on a trial basis, requiring homeowners to reapply for an extension of the terms after only a few months—a process that appears rife with obstacles, according to participants.

“There’s no teeth to the conciliation program,” said Matthew B. Weisberg, a Philadelphia lawyer who represents homeowners in cases involving alleged mortgage fraud. “It’s a largely ineffective stopgap prolonging the inevitable, which is the loss of homes.”

Still, Mr. Weisberg grudgingly praised the plan.

“While it’s arbitrary and unpredictable,” he said, “it’s better than what anybody else is doing.”
SHERIFF DELAYS AUCTION
Philadephia’s Residential Mortgage Foreclosure Diversion Pilot Program began with a resolution passed by the City Council in March of 2007. Sheriff John Dilan then began to scrap the sheriff’s sale schedule for April. Low-income neighborhoods were already experiencing a surge of foreclosures involving subprime mortgage companies. Dilan subsequently stopped the sale of foreclosed properties, which cost $247 billion in additional tax increases, which are multiple and cumulative in the bill, so that when the bill starts to kick in until January 1 of 2010, while much of the spending in the bill start to kick in until January 1 of 2010, while much of the provisions to take effect. So you can look very closely at what is in the bill. It should come as no surprise that it is a $247 billion hole—$247 billion in additional tax increases, which are multiple and cumulative in the bill, so that when the bill starts to kick in until January 1 of 2010, while much of the spending in the bill would do, what it entails, and how, with all the rhetoric about how it differs and improves upon previous drafts of the bill, it comes down to basically the same elements that have been in all the bills we have seen. First is with respect to the costs. It is very clear the cost of this bill—which was stated last night as $409 billion—dramatically understated relative to its true cost when fully implemented. The reasons are simple. One, they push back the effective implementation date to 2014 for many of the provisions to take effect. So you will not see the actual spending in the bill start to kick in until January 1 of 2014. However, many of the revenue components in the bill begin to kick in next year, on January 1, 2010. So the tax increases, which are multiple and hundreds of billions of dollars, would be put into place. The second case, starting January 1, 2010, while much of the spending in the bill would be deferred until much later in the budget window—not taking effect until January 1, 2011. That distorts the true picture of what this legislation would cost and distorts it substantially.

The other point I will make is that there are a couple other provisions in the bill, by its nature, that understate the cost of the bill. One is the absence of the sustainable growth rate formula, or the so-called physician fee fix, the reimbursement form, that is a $247 billion hole—$247 billion in additional spending that is not included in the bill. That, obviously, understates the overall cost.

There is also a $72 billion assumption in there for a program called the CLASS Act. I wish to read for you something that one of my colleagues on the Democratic side said about the CLASS Act. This was the Senator from North Dakota, chairman of the Budget.

HEALTH CARE REFORM
Mr. THUNE. Mr. President, we now have a draft of the Senate majority’s health care reform bill, after spending several weeks behind closed doors producing that bill. Some of the details are starting to emerge, and it is critical that all Members in the Senate have an opportunity to look very closely at what is in the bill. It should come as no surprise that it is a 2,000-page plus bill. Much was made of the bill in the House of Representatives being a 2,200-page bill when it was all said and done. This one is nearly 2,074 pages. It hasn’t been amended yet, so that will probably expand it as this bill comes to the floor.

I think we at least now have something we can look at and review. There was a lot made last night by the majority when they rolled this bill out—how fiscally responsible this bill is and how much of an improvement it is over recent drafts of this legislation. I wish to point out a couple things that I think, put into perspective what this bill would do, what it entails, and how, with all the rhetoric about how it differs and improves upon previous drafts of the bill, it comes down to basically the same elements that have been in all the bills we have seen.

First is with respect to the costs. It is very clear the cost of this bill—which was stated last night as $409 billion—dramatically understated relative to its true cost when fully implemented. The reasons are simple. One, they push back the effective implementation date to 2014 for many of the provisions to take effect. So you will not see the actual spending in the bill start to kick in until January 1 of 2014.

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There is also a $72 billion assumption in there for a program called the CLASS Act. I wish to read for you something that one of my colleagues on the Democratic side said about the CLASS Act. This was the Senator from North Dakota, chairman of the Budget.
Committee in the Senate. He called the CLASS Act “a ponzi scheme of the first order, the kind of thing that Bernie Madoff would be proud of.” That is how he refers to this CLASS Act included in the bill and the savings that are associated with it. In fact, the bill as it shows the revenue in the first 10 years turns into a deficit in the second 10 years. So when you back out the $72 billion that, it is assumed, would add to the revenues in the bill and you add to the cost of the $2.97 trillion that would be required to fund the physician fee formula over a 10-year period, the so-called surplus that this bill generates actually turns into a deficit. It goes from a surplus of $130 billion to a deficit of $189 billion.

Again, a lot of gimmicks are being used to understate the true cost of the bill to the American people. All that being said, if you look at the overall cost, when fully implemented over 10 years, you come up with this: Remem- ber, when the Finance Committee passed its version of this bill out of committee, the 10-year, fully-implemented cost was $2.2 trillion.

When the Finance Committee passed its version of the health care reform bill out of the Finance Committee, the fully-implemented cost of that bill was $1.8 trillion. So that is $1.8 trillion for the Finance Committee bill and $2.2 trillion for the Health, Education, Labor, and Pensions Committee bill. Guess what? The Finance Committee bill that was merged together and has now been unveiled for all the world to see. It is $2.5 trillion in overall cost—10-year, fully-implemented cost. That is a $2.5 trillion expansion of the Federal Government in Washington, DC, associated with the fully implemented cost of the bill.

The point I am trying to make is this: The cost of the bill is being dramatically understated by the authors of the Finance Committee, it looks like it comes in under $1 trillion, when, in fact, when you back out the two components I mentioned, it is over $1 trillion in the first 10 years, and that is because they delay implementation of many provisions until January 1, 2014—a budgetary gimmick designed to understate the true cost of the bill.

When you look at the fully implemented, 10-year cost of the legislation, without the gimmick of the delayed implementation, it looks like it comes in under $1 trillion, when, in fact, this bill as it is written—this bill as it is written is a $2.5 trillion in additional costs to the taxpayers of this country. Of course, that $2.5 trillion has to be paid for somehow. The way it is paid for isn’t any different than in any of the other bills we have seen so far. It is paid for with higher taxes on small businesses and higher taxes on individuals. It is paid for with cuts to Medicare Programs that would impact senior citizens in this country, as well as medical providers, from hospitals, to home care agencies, to hospice—you name it—and medical device manufacturers get hit hard in this legis- lation. Everybody gets hit when it comes to the reimbursement side to pay for this.

Of course, the American taxpayer gets hit hard when it comes to the tax increases included in there—$0.5 trillion in tax increases and $0.5 trillion in Medicare. The 2.5 trillion expansion of the Federal Govern- ment to create a new entitlement program. The other thing this bill does, which wasn’t included in a previous version, it has an increase in the payroll tax on Medicare. The argument is, it only applies to people in the higher income categories. They tried to carve out people under $200,000 a year. Remember, the Medicare tax—and the payroll tax that every employee in this country pays, which is 1.45 percent on their in- come, matched by their employer, for a total of 2.9 percent—is increased. It gets increased to pay for not reforming or making Medicare more sustainable, a program we all know is destined to be bankrupt in the future.

The increase in the Medicare tax will fund a whole new entitlement program unrelated to Medicare. The argument will be it is a health care program. But the fact is, the Medicare payroll tax was put in place to fund Medicare, a program people would pay into so that when they retire, they would have the security of health care coverage. The payroll tax included in this bill, first off, will hit a lot of people. If you are in this happy couple hundred—or $100,000 a year, you are already into the category where you are going to be hit by the tax. One of my main objections—and I am not for this tax increase—one of my main objec- tions is the majority has chosen to use that tax increase not to make Medicare more sustainable but to create a whole new entitlement program with this bill.

The other thing I wish to point out, because it has come up in the last day or two, is there has been all this dis- cussion about mammograms, this U.S. Preventive Services Task Force that came out with a recommendation that women under 40 should not go through mammogram screening; and, of course, a few years ago they made the opposite recommendation—back in 2002—when the U.S. Preventive Services Task Force made the recommendation that women 40 and older should undergo an- nual screening for breast cancer. That recommendation was completely reversed earlier this week. The 16-member task force ruled that patients under 50 or over 75, without special risk factors, no longer need annual screening. What is being said about that? The whole mucking away from that in a hurry. The HHS Sec- retary, Kathleen Sebelius, said: No, no, no, nothing will change. This is just a recommendation. It is not binding.

That may be true today. Here is the problem with government-run health care, the problem with the direction we are heading with this legislation: A greater level of government involve-
who, by virtue of that screening process and that test, have been detected early and able to beat breast cancer, which is something that afflicts a great number of women across this country.

That is one example. I use that as an example of how this new type of government-run program might work. But there are countless other examples of the very same thing.

As we head into this debate, again I remind my colleagues this type of underwriting reforming health care ought to be about driving down costs, it ought to be about providing more access to Americans, it ought to be about maintaining that important relationship between a physician and their patient and not getting to where we have the government making those decisions, where we are actually bending the cost curve up rather than driving it down.

By the way, the CBO said in response to the majority’s bill that was unveiled yesterday that it actually increases costs by $160 billion. To me, the fundamental goal of health care reform for most Americans, the key concern they have about health care today, is its costs. Everything we have seen so far, including the most recent version which we are going to have at some point on the floor of the Senate, probably sometime after the Thanksgiving holiday, increases costs, drives the cost curve up.

How can you be for something that cuts Medicare to providers and seniors across this country, that raises taxes on small businesses, the economic engine that creates jobs in this country, raises taxes on middle-income Americans and which also, ironically, raises the cost of health care, increases the cost of health care? I am not saying this is the CBO. That has been consistent through all the bills that have been produced. It is consistent with this theme and the proposal and all the new provisions that will be included—again, $2.5 trillion, 10-year fully implemented costs paid for by Medicare cuts, $3 trillion in Medicare cuts, $½ trillion in tax increases, and obviously much more than that when you get into the fully implemented time period, all that—all that—to raise health care costs for people in this country. How can we label that reform?

I hope the American people, as they listen to this debate, will engage, will weigh, will take a hard look at this 2,074-page bill. It is going to be a lot of legislative, arcane language. We are all going to do our best to make sense out of it. But it is a massive bill, just in terms of its volume. It also includes a massive expansion of the Federal Government in Washington, DC, at tremendous cost to the taxpayers, to Medicare beneficiaries and, in the end, doesn’t do anything to drive down the cost of health care. It simply increases it and puts more of those decisions in the hands of the things I talked about with regard to breast cancer screening. When government is making decisions rather than patients and doctors, that is a world in which I don’t think I want to enter, and certainly I think most Americans don’t either.

Mr. President, I ask unanimous consent to have printed in the Record a Wall Street Journal editorial.

There being no objection, the material was ordered to be printed in the Record, as follows:

**A BREAST CANCER PREVIEW**

A government panel’s decision to toss out long-time recommendations for breast cancer screening is causing an uproar, and well it should. This episode is an all-too-instructive review of how health-care decisions about cost-control and medical treatment that are at the heart of ObamaCare. As recently as 2002, the U.S. Preventative Services Task Force came out in its recommendation that women 40 and older undergo annual mammograms to check for breast cancer. Since regular mammography became standard practice in the early 1960s, mortality from breast cancer—the second leading cause of cancer death among American women—has dropped by about 30%, slower than the progress over the prior half-century. But this week the 16-member task force ruled that patients under 50 or over 75 without special risk factors no longer need screening.

So what changed? Nothing substantial in the clinical evidence. But the panel—which includes cancer biologists and radiologists who best know the medical literature—did decide to re-analyze the data with health-care spending as a core concern. The task force recognizes that the benefits of early detection are the same for all women. But according to its review, because there are fewer cases of breast cancer in younger women, it takes 1,904 screenings of women in their 40s to save one life and only 1,389 screenings to do the same among women in their 70s. The panel concludes that the tests for the first group aren’t valuable, while also noting that screening younger women results in more false positives that lead to unnecessary follow-up tests or biopsies. Of course, this calculation doesn’t consider that at least 40% of the patient years of life saved by screening women under age 50. That’s a lot of women, even by the terms of the panel’s own statistical abstractions. To put it another way, 665 additional mammograms are required to save one aggregate. But at the individual level they are immeasurably valuable, especially if you happen to be the woman whose life is saved.

The recommendation to cut off all screening in women over 75 is equally as myopic. The committee notes that the benefits of screening older women are equivalent to several years after the actual screening test, whereas the percentage of women who survive long enough to benefit decreases with age. It adds that women who are at greater risk for dying of other conditions that would not be affected by breast cancer screening. In other words, grandma is probably going to die anyway, so why waste the money to reduce the chances that she dies of a leading cause of death among elderly women?

The effects of this new breast cancer cost-consciousness are likely to be large. Medicare generally adopts the panel’s recommendations when it makes coverage decisions for seniors, and the panel’s judgments play a large role in private insurance markets. Yes, people could pay for mammography out of pocket. This is fine with us, but it is also emphatically not the world our first-generation baby boomers live in, in which reimbursement decisions deeply influence the practice of medicine.

More important for the future, every Democratic version of ObamaCare makes this task force an arbiter of the benefits that private insurers will be required to cover as they are converted into contractors. What are now merely recommendations will become de facto rules, and under national health care these kinds of cost analyses will inevitably become more common as government decides where finite tax dollars are allowed to go.

In a rational system, the responsibility for health care ought to reside with patients and their doctors. James Thrall, a Harvard medical professor and chair of the American College of Radiology, tells us that the breast cancer decision shows the dangers of medicine being reduced to “accounting exercises subject to interpretations and underlying assumptions,” and based on costs and large group averages, not individuals.

“I fear that we are entering an era of deliberate decisions where we choose to trade people’s lives for money,” Dr. Thrall concluded. He’s not overstating the case, as the 12% of women who will develop breast cancer during their lifetimes may now better appreciate.

More spending on “prevention” has long been a priority of health reformers, and President Obama has been especially forceful. In his health speech to Congress in September, the President made minimizing “routine checkups and preventative care, like mammograms and colonoscopies—because there’s no reason we shouldn’t be catching diseases like breast cancer and colon cancer before they get worse.” It turns out that there is, in fact, a reason: Screening for breast cancer will cost the government too much money, even if it saves lives.

**HEALTH CARE REFORM**

Ms. STABENOW. Mr. President, I ask unanimous consent to speak for up to 20 minutes in morning business.

The PRESIDING OFFICER. Without objection, it is so ordered.

The PRESIDING OFFICER. The Senator from Michigan.

**Ms. STABENOW.** Mr. President, first, it is a good thing our health care reform doesn’t do the kinds of things the Senator is talking about. I wouldn’t support it either if the Chair would either. It is a good thing that is not what we are doing. With respect to my friend from South Dakota, we have a different view of this bill. Let me first start by saying, as the Chair knows and as the Wall Street Journal said, this bill saves lives and saves money, and particularly protects Medicare and stops insurance abuses. That is what we are about.

Before going through the specifics of the bill, I wish to read from a very interesting column today in the New York Times. We can have competing newspapers, but the New York Times is ours,...
that Washington bureaucrats will invade “the privacy of the examination room,” that we are on the road to rationed care and that patients will lose the “freedom to choose their own doctor.”

All dire—but also wrong. Those forecasts date not from this year, but from the battle over Medicare in the early 1960s. The heirs of those bogymen [today], the insurance companies—that is what we hear from the insurance industry at that time—are conjuring the same bogymen [today].

Indeed, these same arguments we hear today against health reform were used even earlier, to attack President Franklin Roosevelt’s call for Social Security.

I appreciate the concerns that have been raised, but this is a replay of a time in the sixties when there was a debate about whether seniors who couldn’t find affordable insurance in America should have access to the health care they need and the insurance they need.

Thank goodness, Democrats at that time, the President, and the Democratic majorities in the House and the Senate, chose to stand up for seniors and to override the objections coming from the insurance companies and the insurance lobby and those making money off the system at that time.

Let me be clear about what is at stake if we do nothing, because that is the first question. Why should we be doing something? Every single day—in fact, today—34,000 Americans got up with health insurance and by the time they go to bed tonight, they will not have it because they have lost their job, because their business had to drop them because the costs went up too much, because they couldn’t afford the explosion in premiums and copays.

Insurance rates will almost double by 2016 for families, up to $24,000 for a family of four. Businesses will see their costs double in the next 10 years. What is extremely concerning to me as a Senator of the great State of Michigan, where hundreds of employers need health care, employers doing the right thing, working hard to try to continue to provide health care coverage, those increased costs, doubling the costs over the next 10 years will, in fact, cost us 3.5 million jobs. Health care reform is about saving jobs.

Family incomes will be reduced by $10,000. Every single day—right now—5,000 homes are foreclosed. About half the homes that are foreclosed every day are foreclosed because of a medical crisis, because those families have lost insurance but it did not cover the cost of their medical expense. And we know that 62 percent of the bankruptcies today are because of a health care crisis and health care bills.

The status quo is not acceptable. Doing nothing means costs will go up. The insurance industry will still stand between you and your doctor deciding the kind of care you should get and the doctors you should see. In many cases, most plans require a certain set of doctors, but paying for those things the doctor needs to do and wants to do in total to help you recover from an operation or have the treatment you need.

We are going to, importantly, reduce long-term costs, lower the deficit and reduce long-term spending. If we do nothing, costs will continue to go up and up and, unfortunately, because of family costs and business costs, we are likely to see care go down and down as they struggle to keep their heads above water.

I want to talk a little bit more about Medicare. This is so important, as we know. We are going to strengthen Medicare. We know, again, if we do nothing, it is predicted the Medicare trust fund will be insolvent in 2017. We have to act.

We are doing a number of things both to bring down costs by focusing on prevention, saying to seniors and people with disabilities that if you go in for that annual checkup, if you go in for preventive work and, yes, mammograms for the women, you will be able to see the specialist you want to see. Business as usual is OK. Higher costs for middle-class families and small businesses are OK.

We believe these things are not OK, that doing nothing is only going to explode the deficit, hurt businesses, hurt families. We are prepared to act.

What does this mean in saving lives and saving money? First, it strengthens and protects Medicare. I will talk a little bit more about that. Lowering costs for small businesses and families. We know right now the majority of those who are uninsured are working. They are working in a small business or they are working out of their home as a single entrepreneur. They are in their garage, frequently working on that next invention, or they are out as a realtor in the community.

For years we have been saying we should pool small businesses and entrepreneurs into a larger pool so they could get a better rate, such as a big business. That is what this is about. Amazingly, this big government takeover we hear so much about is for less than 20 percent of the people in the country right now. Eighty percent of the people in the country get their insurance through their employer—about 60 percent. The rest through a public program of some kind—Medicare, VA for veterans, our military, Medicaid.

We want to change the game in the gaps for small businesses and individuals, providing them tax cuts so that health insurance is more affordable and pooling them together. That is what this is about.

We are going to stop the insurance company bad practices as I talked about before. We are going to focus on prevention and quality which saves us money over time. In fact, one of the biggest ways we will save money is by focusing on keeping people healthy, focusing on ways that we change a system so we are not paying for individual procedures, but paying for those things the doctor needs to do and wants to do...
The reality is, this is a great American success story, and we want to keep it that way.

The reality is also that the AARP Web site talks about the myth that health care reform will hurt Medicare. This is from them, from their Web site. I welcome anyone to check it out. The myth is that we will be hurting Medicare.

Fact: None of the health care reform proposals being considered by Congress would cut Medicare benefits or increase your out-of-pocket costs for Medicare services.

None of them would cut Medicare benefits or increase your out-of-pocket costs.

Fact: Health care reform will lower prescription drug costs for people in the Medicare part D coverage gap or “donut hole” so they can better afford the drugs they need.

Fact: Rather than weaken Medicare, health care reform strengthens the financial status of the Medicare program.

This is from AARP, not from the Senate, not from Democrats. This is from a group whose job, whose mission is to analyze what we are doing here and call it as they see it on behalf of those who receive Medicare benefits.

It would be terrific if that stopped being a talking point.

Let me talk a little more about insurance reform.

When you have insurance now or whether you are in the less than 20 percent who are without insurance today, affordable insurance, who will be going into this new pool we have, the insurance exchange—we see broad changes that will help our patients. We really are talking about patients, consumers, families benefiting from insurance reform.

We are going to end discrimination for preexisting conditions, whether your child has leukemia and you are worried about whether at some point they are going to be able to find insurance on their own as they get older, a child with disabilities, or someone with juvenile diabetes. Unfortunately, we have also seen this used to discriminate against women. We have seen insurance companies say pregnancy is a preexisting condition and use it not only against women but against men who are expectant fathers. We want to make it very clear that you cannot be discriminated against if you have had a temporary or a permanent health condition.

We are going to stop the practice of dropping you if you become seriously ill. I don’t know how many times I have heard from people in Michigan who are doing just that. You are doing fine, I am paying my insurance premiums, I have insurance coverage, I am doing fine. But they have never really had to use the insurance. They have been fortunate that no one in their family has gotten seriously ill. Then something happens—a cancer, serious car accident, some other diagnosis that is very serious—and then in too many cases we have seen the insurance company come knocking on the door in order to be able to drop them because they are now having to pay out money for health care. That is wrong. This process of rescissions needs to stop, and under health reform it will.

We also say that as a matter of policy under insurance, preventive care should be free. You are paying a premium but no copays and deductibles. We want people to be able to go to the doctor to get the annual visit, to be able to get the screenings, to be able to get the other preventive services they need. We want to save lives. This saves lives and saves money.

We want to make sure that happens.

Then we are eliminating the annual and lifetime caps, to be able to address the caps as well.

Also, I am very pleased about two other provisions I think are so important for families. One is to allow young people to be able to stay on their parents’ insurance. I wish that had been in place a couple of years ago, actually. I know from experience that the first job a young person may get out of college may not have health insurance or they may come out of college and go into one of those part-time jobs in order to put things together while looking for work. This is very important for young people, to give them the opportunity to stay on their parents’ insurance until age 26. This is one of the provisions that will start immediately when the bill is enacted. I believe it is very important.

Another provision that will happen immediately that is particularly important for many people in my wonderful State of Iowa will help in having to hold down costs for early retirees. I was proud to be the author, with Senator KERRY, of this provision. We have many people who are retiring at age 55. It may not be voluntary. To many people, it is not voluntary. If the company continues the insurance, it is expensive. A person is not eligible for Medicare yet, and when they are retired early, someone 55 to 64 is usually using more medical care, more health care services and will take the costs out of the retirement costs.

We also now have situations such as the United Auto Workers have decided, in order to help their industry and their companies, that they would assume the costs of retiree insurance, and early retirees are finding it extremely difficult, as they put together the numbers, to pay for care. Going forward, when this bill passes we will be a partner with those businesses or entities providing early retiree insurance, by providing coverage for catastrophic care, but basically above a certain amount we will cover it as the Federal Government. Above a $15,000 amount of a particular health care cost or treatment, the company will know that the Federal Government will reimburse or cover that. That means the exposure for the company is capped, which means their costs will not go up. In fact, they should go down significantly for early retirees.

It also allows as well should be able to more accurately plan based on this partnership between businesses, employer-based care, and the Federal Government. This is very significant.

As I close, it is very important to stress what this is all about. There are many pieces to this. I invite anyone from Michigan, as we have done all year, to go to my Web site. We have the entire bill posted. We have done this at every step of the way. We will continue to do that as the debate moves forward, with amendments and so on. We welcome people to get engaged.

I have a Health Care People’s Lobby that folks can sign up for e-mail, and we will keep you posted on what is happening, and you can share your thoughts, your feelings, and your stories about what health care reform would mean to you or what has happened to you as someone needing health care or not getting the health care help from your insurance company that you believe you should as someone who has been paying for health care.

We are in a position now, we are poised to do something that I believe should have been done years ago. Many have tried to do it.

I commend this President for making health care, health insurance reform, a top priority; for understanding that we are losing jobs overseas because we are not competitive internationally with other countries, that health insurance reform is about jobs. It is about saving jobs. It is about the cost of losing your insurance. It is about businesses seeing that the costs go up, and the moral imperative that says, if you lose your job, you should not lose your health insurance in the greatest country in the world.

This is about saving lives at every level. It is about saving money at every level—for families, individuals, small businesses, larger businesses, States, the Federal Government. This is about tackling what has become a huge cost to our economy and beginning to turn that around. We have to begin to turn this ship so we can get these costs under control. Saving lives, saving money, protecting Medicare for the future, and stopping the insurance abuses that occur every day for too many families—that is what health insurance reform is all about.

I am so pleased and proud of our leader, Senator REID, and grateful for his leadership and amazing skill in bringing us to this point. I am so grateful for the leadership of Senator BAUCUS in Finance and Senator OnePlus and Senator HARKIN on the HELP Committee and everyone who has been involved in this effort.
It is worth the time, whatever it takes, to do this and get it right. Saving lives and saving money for American families and businesses, protecting Medicare, stopping insurance abuses—this is worth fighting for. I am very proud to be part of a group of people who have placed this as a top priority.

I yield the floor.

The PRESIDING OFFICER. The Senator from Delaware is recognized.

INAUGURATION OF THE PRESIDENT OF AFGHANISTAN

Mr. KAUFMAN. Mr. President, today, I rise to recognize the inauguration of President Karzai, as he begins his second term as President of Afghanistan. This milestone presents a unique opportunity to begin a new chapter in Afghanistan's history, which I hope will be characterized by transparency, governance, accountability, and an even stronger partnership with America.

Our two governments share common interests in the success of Afghanistan and the stability of the region. When President Karzai during his September visit to Kabul, we discussed counterinsurgency strategy and the importance of stronger governance at all levels—national, provincial, and district. Counter-insurgency strategy has proven effective throughout history, and good governance is essential for its success.

President Karzai knows that he must garner greater support among the Afghan people for his government because, ultimately, this is a battle for legitimacy between the Afghan government and the insurgents. We will continue to partner with the Afghans to defeat the Taliban, but counter-insurgency cannot succeed if the Afghan people believe their government is plagued by corruption.

I welcome President Karzai’s recognition of corruption as a “dangerous enemy of the state” in his inaugural address earlier today.

His intention to create an anti-corruption unit is an important step to this end, but words are not enough. He must match this rhetoric with action, and immediately take steps to effectively address the problem.

No government official is above the law, and all should be held accountable for their actions. Numerous criminal cases involving government officials—such as recent allegations that the Afghan Minister of Mining accepted a $30 million bribe as part of an illicit deal with a joint mining firm—must be thoroughly investigated.

As President Karzai said today, government officials should register their government functions more effectively in providing essential services. In order to fulfill these two goals, I urge President Karzai to appoint competent governors and cabinet members who respect the rule of law and human rights, and who are vocally committed to the people of Afghanistan. The stakes are too high to revert tocronyism. Now is the time for President Karzai to appoint and support capable, effective, and law-abiding public servants.

The essential defense against the Taliban is an effective Afghan government. As such, I urge President Karzai to work with the United States and other international partners to produce specific and measurable guidelines for combating corruption, improving governance transparency and accountability, providing essential services, strengthening rule of law tackling the drug trade, and improving the economic infrastructure.

Clear benchmarks must be set, and progress must be monitored to ensure compliance.

This plan cannot be limited to Kabul. It is critical that government officials throughout the country are well qualified and empowered with the necessary authorities and budgets to improve the lives of all Afghans. We must work together to undermine the Taliban’s foothold and role as the de facto provider of rule of law, and basic services, especially in southern Afghanistan.

In addition to good governance and essential services a third element of success in counterinsurgency is the training and deployment of effective national security forces.

I welcome President Karzai’s stated intention to assume complete Afghan control over security within 5 years. I also echo his calls for NATO partners to take steps to accelerate the training of the Afghan National Army—ANA and Police—ANP.

Currently there are not enough Afghan and international forces on the ground to “clear and hold” against the Taliban. In fact, the number of trained Afghan security forces is less than one-third that of Iraq—a geographically smaller country with nearly the same-sized population.

The training of the ANA and ANP must be expedited to build a stronger force of needed counterinsurgents, with the near-term goal of transferring responsibility to the Afghans.

During my two trips to Afghanistan this year, it was clear that the Afghan people identified security as a key concern, and wanted a swift transition from international to Afghan forces. Americans also hope for a swift transition, so we can eventually end our military presence and bring our brave troops home to their families.

I fundamentally disagree with accusations by some in Afghanistan—including President Karzai—that the U.S. presence in Afghanistan is purely self-serving. We are committed to working with President Karzai to secure our shared objectives. It has been said that nations have no permanent allies, only permanent interests. As we stand on the cusp of history together, the United States and Afghanistan are united by shared goals and coinciding interests.

As President Obama outlined in March, it is America’s goal to disrupt terrorist networks in Afghanistan, to defeat al-Qaida, and to help to promote a more capable and effective Afghan government. The way to do this is to partner with the Afghan people to defend them against a resurgent Taliban. As Secretary Clinton said, these are mutually reinforcing missions.

There is an underlying urgency to this joint venture, and we cannot succeed without a true partner in the Afghan government.

In his inaugural address, President Karzai said the right things. Now is the time for implementation. During my visits to Afghanistan, I was impressed by the resolve and vision of the brave people of Afghanistan. In the face of enormous challenges, the majority of Afghans have rejected the Taliban’s oppression and chosen to seek a better life for future generations.

Today represents an opportunity for President Karzai to fulfill the hopes and dreams of his people, and bring greater peace and prosperity to Afghanistan through good governance.

As he begins his second term, President Karzai must forge a path that will lead to a brighter future, free from corruption. We need leadership, resolve, and determination, if we are to be successful in Afghanistan.

AMERICAN EDUCATION WEEK

Mr. FEINGOLD. Mr. President, this week I join my colleagues, and the Nation in observing the 88th annual American Education Week.

The United States of America has a rich history of providing a free public education to its children, and the education that millions of students receive every year opens countless doors of opportunity to these students. Teachers, administrators, and support staff in our Nation’s communities plant the seeds of knowledge in our students, who are the future of the American economy, American innovation, and American society. And sometimes I do not feel like enough is said of these individuals who have dedicated their lives to the cause of public education and who have touched the lives of millions of children. Let us reflect on the positive impact teachers and schools have on this country.

While enormous strides have been made in expanding access to public education since our Nation’s founding, the United States still has a long way to go before we can say that every child in our Nation has access to a high-quality public education. There is
still a persistent achievement gap in many of our Nation’s schools with respect to low-income and minority students. The nationwide high school graduation rate hovers around 70 percent and is even lower for students of color. These gaps are unacceptable and is a matter of fairness and equality that must be addressed. We can do better. We must do better. The future of our country rests on our efforts. Federal, State and local governments must work together to continue to support our educators and help ensure that every child has access to good teachers and high-quality schools.

That is why I am looking forward to working with educators as Congress undertakes the reauthorization of the Elementary and Secondary Education Act, also known as No Child Left Behind. We now have the opportunity to rethink the proper role for the Federal Government in education reform and how we can support States and school districts as they continue to work to educate all our Nation’s children and close the persistent achievement gap that still exists in too many of our Nation’s schools. We need to work together to solve problems, strengthen our public school system, and make certain that all our students receive the education they deserve.

As Chief Justice Warren wrote when he delivered the opinion of the Supreme Court in the landmark Brown v. Board of Education decision:

Today, education is perhaps the most important function of state and local government. Compulsory school attendance laws and the great expenditures for education both demonstrate our recognition of the importance of education to our democratic society. It is required in the performance of our most basic public responsibilities, even service in the armed forces. It is the very foundation of good citizenship. Today it is a principal instrument in awakening the child to cultural values, in preparing him for later life, and in helping him to adjust normally to his environment. In these days, it is doubtful that any child may reasonably expect to succeed in life if he is denied the opportunity of an education. Such an opportunity, where the state has undertaken to provide it, is a right which must be made available to all on equal terms.

More than 50 years later, these words still ring true, and as we celebrate American Education Week, let us honor the outstanding work that our Nation’s educators do every day and recommit to work closely with these educators to address the continued inequities in American education so that all children, regardless of their background, can receive a high-quality public education.

COMBATING HUNGER

Mr. CARDIN. Mr. President, as we prepare to depart for the Thanksgiving break, I wish to thank those who work to combat hunger in this country and to commend the administration for its goal of eliminating child hunger by 2015. I encourage the administration to work with Congress to find solutions to achieve this goal and end hunger in America.

We must commit ourselves to solving this crisis. The U.S. Department of Agriculture has just released findings that 13.5 million American children—or 17 percent of all children—in the United States were “food insecure,” up from 11.1 percent in 2007. Food insecurity is measured by the number of persons who experience hunger at some point during the year because they could not afford enough food for their diets.

The Agriculture Department also found that one-third of these households had what the researchers called “very low food security,” which means that they were forced to skip meals or cut portions. The other two-thirds of households got by only through reliance on food stamps, soup kitchens, and food pantries.

The nearly 4 percent increase in food insecurity between 2007 and 2008 is the largest since USDA began reporting the figures. Furthermore, more disturbing, USDA reports that nearly 17 million children live in households where food was scarce at some point during the last year. This figure amounts to more than one out of every five American school-aged children.

An astonishing 1.1 million children went to sleep hungry at some point in 2008—a 36 percent increase from 2007. In my State of Maryland, more than 135,000 children currently live in food insecure households. Sixty-three thousand of these children are under the age of 5.

No child should ever know what it means to be hungry. Childhood hunger hinders development in the long term, and children who are hungry have difficulty learning and are at much higher risk of being in poverty as adults. Hunger negatively affects children’s behavior, school performance, and cognitive development.

As we celebrate this holiday season, it is important to reflect on how each of us can support our communities. In my home State, the employees and volunteers at the Maryland Food Bank provide 14 million pounds of food annually to those in need. Working with more than 1,000 partner organizations, including soup kitchens, senior centers, daycare centers and afterschool programs, the food bank works to fill unmet needs of Maryland families. In these difficult economic times, the services of the Maryland Food Bank are more important than ever.

During the past year, the staff at the food bank’s facilities in Baltimore and Salisbury saw demand increase by 50 percent. Middle-class families who a year ago made donations to the food bank are now turning to the organization to put food on their own tables.

Americans with full-time jobs are the fastest growing cohort of those in need. As unemployment continues to rise, families are being forced to spend their savings and are too quickly moving from middle to low income. America’s working poor are most at risk. They live from paycheck to paycheck and have no safety net if their company downsizes or their hours are cut. When money is short, Americans are forced to make excruciating choices.

It is estimated that one-third of Marylanders relying on food assistance must choose between buying food and paying utility bills. Fifty-three percent of those who receive food assistance have unpaid medical bills. The number of working poor families in Maryland is 70 percent higher than it was two decades ago.

In addition to the food bank, I also want to highlight the work of employees at the many social service agencies across our State. These dedicated workers devote their time and energy to helping their community and work side-by-side with the Maryland Food Bank and other organizations to provide meals and services to those in need.

For example, the Maryland Department of Education works closely with the Maryland Food Bank on several projects that provide students with nutritious meals. More than 303,000 Maryland children rely on free or reduced-price meals in schools. Through the Backpack Program, the food bank provides schools such as Baltimore Highlands Elementary with backpacks filled with food. Children receive the backpacks on Friday afternoons to ensure they are not hungry over the weekend.

Kids Cafe is an innovative partnership between the food bank, the Maryland Department of Education, and local afterschool programs that provides nutritious meals and teaches children how to make healthful food choices.

Our seniors are also at risk of food insecurity at much higher levels than the general population. I applaud efforts such as the SNAP Outreach Program in Maryland, which is a partnership between the USDA and local organizations to help register seniors for food assistance programs.

Despite these efforts, we need to do more. In my State alone, it would take $2 million pounds of food to support the more than 350,000 Marylanders in need every year.

We must recommit ourselves to serving our communities and work together to support those in need during these difficult times.

As Senators and staff leave Washington for their home States and prepare to give thanks and enjoy the company of family and friends, I encourage us all to show our support for those who work daily to make mealtime possible for millions of Americans in need.

225TH BIRTHDAY OF FORMER PRESIDENT ZACHARY TAYLOR

Mr. WARNER. Mr. President, today I wish to recognize the 225th anniversary of the birth of MG Zachary Taylor, a Virginia native son and the 12th President of the United States of America.
Best remembered as a distinguished military hero, Zachary Taylor was known as a resourceful, steadfast, modest and compassionate commander who fought many successful battles, earning from his soldiers and countrymen the affectionate nickname "Old Rough and Ready." Zachary Taylor's personal popularity increased as his national prominence spread. General Taylor defeated Henry Clay, Winfield Scott and Daniel Webster for the Whig Party Presidential nomination. Although he had not sought office, Zachary Taylor was elected the 12th President of the United States.

Slavery was the driving issue of the campaign and the primary challenge of Zachary Taylor's brief Presidency. In his inaugural address, Zachary Taylor promised that the preservation of the Union would be his first obligation. He was determined to find a solution to end slavery even though he was a southerner and a slave holder. Zachary Taylor urged settlers in New Mexico and California to bypass the territorial stage and draft constitutions for statehood. As Southern Democrats called for a secession convention, Zachary Taylor reacted with a bristling statement that he would hang anyone who tried to disrupt the Union by force or by conspiracy, setting the stage for the Compromise of 1850.

During his 15 months in office, Zachary Taylor also created the Department of the Interior and signed a treaty with Great Britain guaranteeing a neutral canal connecting North and South America. After laying the cornerstone of the Washington Monument on July 4, 1850, Zachary Taylor fell ill and passed away. An unprecedented 100,000 people lined the funeral route to see the hero laid at rest.

On November 24, 2009, representatives of local, State and Federal Government will honor one of Kansas City's most famous native sons. First Day Issue Zachary Taylor Dollar coins will be given to county schoolchildren. Please join me in commemorating the life of Zachary Taylor and the courage and efforts during his term of office to bring a peaceful end to slavery in the United States.

ADDITIONAL STATEMENTS

TRIBUTE TO PETER S. LEVI

- Mr. BOND. Mr. President, today I wish to honor a fine Missourian, Peter S. Levi. He is more than well as his lifelong commitment to community and economic development. Mr. Levi has worked tirelessly in developing and fostering economic development throughout the Kansas City area. He first became involved in the region as executive director of the Mid-America Regional Council. After 13 years as the executive director, he moved on to become president of the Greater Kansas City Chamber of Commerce.

Mr. Levi's lifelong dedication to the city of Kansas City and surrounding area is evident through his championing of Kansas City and its economic development. As one of the chamber's most effective presidents has seen the chamber grow to represent about 9,000 area businesses while expanding the chamber's annual budget to over $36 million. Along with his work with the Chamber of Commerce he has been an active member of several boards including the Kansas City Symphony, University of Missouri-Kansas City, Midwest Research Institute, University of Kansas Medical Center, and the Jewish Federation of Greater Kansas City.

Mr. Levi is a graduate of Northwestern University, B.A. and the University of Missouri-Kansas City, J.D., masters of law in urban legal affairs. He is married to Enid Levi and they have two sons Josh and Jeff. Mr. Levi will retire from the Greater Kansas City Chamber of Commerce on December 31 of this year. From his honorable service to the community to his incessant leaders within the Chamber of Commerce, Peter S. Levi has always worked to inspire those around him with his vigor, sense of duty, and pride in his community.

With his many Kansas City friends, I thank Peter for his service to the city of Kansas City, and I wish him all the best in his future endeavors.

MEASURES REFERRED

The following bills were read the first and the second times by unanimous consent, and referred as indicated:

H. R. 1839. An act to amend the Small Business Act to improve SCORE, and for other purposes; to the Committee on Small Business and Entrepreneurship.

H. R. 1842. An act to amend the Small Business Act to improve the Small Business Administration’s Small Business Development programs, and for other purposes; to the Committee on Small Business and Entrepreneurship.

H. R. 3014. An act to amend the Small Business Act to provide loan guarantees for the acquisition of health information technology by eligible professionals in small and small group practices, and for other purposes; to the Committee on Small Business and Entrepreneurship.

H. R. 3738. An act to amend the Small Business Investment Act of 1958 to establish a program for the Small Business Administration to provide financing to support early-stage small businesses in targeted industries, and for other purposes; to the Committee on Small Business and Entrepreneurship.

H. R. 3791. An act to amend sections 33 and 34 of the Federal Fire Prevention and Control Act of 1974, and for other purposes; to the Committee on Homeland Security and Governmental Affairs.

ENROLLED BILLS PRESENTED

The Secretary of the Senate reported that on today, November 19, 2009, she had presented to the President of the United States the following enrolled bills:

S. 748. An act to redesignate the facility of the United States Postal Service located at 2777 Logan Avenue in San Diego, California, as the “Cesar E. Chavez Post Office.”

S. 1825. An act to redesignate the facility of the United States Postal Service located at 50 School Street, Orchard Park, New York, as the “Jack F. Kemp Post Office.”

S. 1832. An act to extend the authority for relocation expenses test programs for Federal employees, and for other purposes.

EXECUTIVE AND OTHER COMMUNICATIONS

The following communications were laid before the Senate, together with accompanying papers, reports, and documents, and were referred as indicated:

EC–3724. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled “Airworthiness Directives; Empresa Brasileira de Aeronautica S.A. (EMBRAER) Model ERJ 170 and ERJ 190 Airplanes” ((RIN2120-AA64)(Docket No. FAA–2009–1039)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3725. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled “Airworthiness Directives; Empresa Brasileira de Aeronautica S.A. (EMBRAER) Model ERJ 210 and ERJ 195 Airplanes” ((RIN2120-AA64)(Docket No. FAA–2009–1039)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3726. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled “Airworthiness Directives; Saab AB, Saab Aerosystems Model SAAB 2000 Airplanes” ((RIN2120-AA64)(Docket No. FAA–2009–0909)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3727. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled “Airworthiness Directives; International Aero Engines AG (IAE) V2500–A1, V2527E–A5, V2530–A5, and V2538–DS Turbofan Engines” ((RIN2120-AA64)(Docket No. FAA–2009–2294)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3728. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled “Airworthiness Directives; Turbomeca SA, ARRIBUS 1A Turbohaft Engines” ((RIN2120-AA64)(Docket No. FAA–2009–0348)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3729. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled “Airworthiness Directives; Rolls-Royce plc RB211 Trent 800 Series Turbofan Engines” ((RIN2120-AA64)(Docket No. FAA–2009–1389)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3730. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled “Airworthiness Directives; 328 Support Services GmbH Dornier Model 328–100 and –300 Series Airplanes” ((RIN2120-AA64)(Docket No. FAA–2009–0616)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3731. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled “Airworthiness Directives; Airbus Model A340–200 and –300 Series Airplanes” ((RIN2120-AA64)(Docket No. FAA–2009–0607)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3732. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled “Airworthiness Directives; Managing, pursuant to law, the report of a rule entitled “Approval and Promulgation of Air Regulations (44 CFR Part 246, Subpart A)” ((RIN2325–A306) received in the Office of the President of the Senate on November 17, 2009; to the Committee on Banking, Housing, and Urban Affairs.

EC–3740. A communication from the Secretary, Division of Investment Management, Securities and Exchange Commission, transmitting, pursuant to law, the report of a rule entitled “Capital Formation Act of 2009” ((44 CFR Part 246, Subpart A)” ((RIN2325–A306) received in the Office of the President of the Senate on November 17, 2009; to the Committee on Banking, Housing, and Urban Affairs.

EC–3741. A communication from the Director of the Regulatory Management Division, Office of Policy, Economics, and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled “Approval and Promulgation of Air Regulations (44 CFR Part 246, Subpart A)” ((RIN2325–A306) received in the Office of the President of the Senate on November 17, 2009; to the Committee on Environment and Public Works.

EC–3742. A communication from the Director of the Regulatory Management Division,
S. 192
At the request of Mr. DODD, the name of the Senator from Pennsylvania (Mr. SPECTER) was added as a cosponsor of S. 182, a bill to amend the Fair Labor Standards Act of 1938 to provide more effective remedies to victims of discrimination in the payment of wages on the basis of sex, and for other purposes.

S. 322
At the request of Mrs. FEINSTEIN, the name of the Senator from Nebraska (Mr. JOHANNS) was added as a cosponsor of S. 332, a bill to establish a comprehensive interagency response to reduce lung cancer mortality in a timely manner.

S. 455
At the request of Mr. ROBERTS, the name of the Senator from Connecticut (Mr. LIEBERMAN) was added as a cosponsor of S. 455, a bill to require the Secretary of the Treasury to mint coins in recognition of 5 United States Army Five-Star Generals—George C. Marshall, Douglas MacArthur, Dwight D. Eisenhower, Henry “Hap” Arnold, and Omar Bradley, alumni of the United States Army Command and General Staff College, Fort Leavenworth, Kansas, to coincide with the celebration of the 132nd Anniversary of the founding of the United States Army Command and General Staff College.

S. 850
At the request of Mr. KERRY, the name of the Senator from Iowa (Mr. GRASSLEY) was added as a cosponsor of S. 883, a bill to require the Secretary of the Treasury to mint coins in recognition and celebration of the establishment of the Medal of Honor in 1861, America's highest award for valor in action against an enemy force which can be bestowed upon an individual serving in the Armed Services of the United States, to honor the American military men and women who have been recipients of the Medal of Honor, and to promote awareness of what the Medal of Honor represents and how ordinary Americans, through courage, sacrifice, selfless service and patriotism, can challenge fate and change the course of history.

S. 1067
At the request of Mr. ROBERTS, the names of the Senator from Alabama (Mr. SESSIONS), the Senator from Texas (Mr. CORKY) and the Senator from Utah (Mr. HATCH) were added as cosponsors of S. 1147, a bill to prevent tobacco smuggling, to ensure the collection of all tobacco taxes, and for other purposes.

S. 1396
At the request of Mr. SCHUMER, the name of the Senator from Virginia (Mr. WARNER) was added as a cosponsor of S. 1536, a bill to amend title 23, United States Code, to reduce the amount of Federal highway funding available to States that do not enact a law prohibiting an individual from writing, sending, or reading text messages while operating a motor vehicle.

S. 1599
At the request of Mr. KERRY, the name of the Senator from Pennsylvania (Mr. CASEY) was added as a cosponsor of S. 1599, a bill to consolidate democracy and security in the Western Balkans by supporting the Governments and people of Bosnia and Herzegovina and Montenegro in reaching their goal of eventual NATO membership, and to welcome further NATO partnership with the Republic of Serbia, and for other purposes.

S. 1703
At the request of Mr. BARRASSO, the name of the Senator from Wyoming (Mr. ENZI) was added as a cosponsor of S. 1703, a bill to suspend temporarily the duty on certain acrylic fiber tow containing a minimum of 92 percent acrylonitrile.

S. 1709
At the request of Mr. THUNE, the name of the Senator from Wyoming (Mr. ENZI) was added as a cosponsor of S. 1709, a bill to amend the National Agricultural Research, Extension, and Teaching Policy Act of 1977 to establish a grant program to promote efforts to develop, implement, and sustain veterinary services, and for other purposes.

S. 1780
At the request of Mrs. LINCOLN, the name of the Senator from Iowa (Mr. GRASSLEY) was added as a cosponsor of S. 1780, a bill to amend title 98, United States Code, to deem certain service in the reserve components as active service for purposes of laws administered by the Secretary of Veterans Affairs.
November 19, 2009

CONGRESSIONAL RECORD — SENATE

S. 1859

The request of Mr. Rockefeller, the name of the Senator from Michigan (Ms. Stabenow) was added as a cosponsor of S. 1859, a bill to reinstate Federal matching of State spending of child support incentive payments.

S. 1963

At the request of Mr. Akaka, the name of the Senator from North Carolina (Mr. Burr) was added as a cosponsor of S. 1963, a bill to amend title 138, United States Code, to provide assistance to caregivers of veterans, to improve the provision of health care to veterans, and for other purposes.

S. 2128

At the request of Mr. LeMieux, the names of the Senator from Idaho (Mr. Risch) and the Senator from Georgia (Mr. Chambliss) were added as cosponsors of S. 2128, a bill to provide for the establishment of the Office of Deputy Secretary for Health Care Fraud Prevention.

S. 2727

At the request of Mr. Lugar, the names of the Senator from Arizona (Mr. Kyl), the Senator from Tennessee (Mr. Vitter), the Senator from Massachusetts (Mr. Kerry) and the Senator from Delaware (Mr. Kaufman) were added as cosponsors of S. 2727, a bill to provide for continued application of arrangements under the Protocol on Inspection and Coordinating Activities Relating to the Treaty Between the United States of America and the Union of Soviet Socialist Republics on the Reduction and Limitation of Strategic Offensive Arms in the period following the Protocol’s termination on December 5, 2009.

S. 2730

At the request of Mr. Brown, the name of the Senator from New Jersey (Mr. Menendez) was added as a cosponsor of S. 2730, a bill to extend and enhance the COBRA subsidy program under the American Recovery and Reinvestment Act of 2009.

S. 2743

At the request of Ms. Snowe, the name of the Senator from New Jersey (Mr. Menendez) was added as a cosponsor of S. 2743, a bill to amend title 10, United States Code, to provide for the award of a military service medal to members of the Armed Forces who served honorably during the Cold War, and for other purposes.

S. 2767

At the request of Mr. Thune, the name of the Senator from Alabama (Mr. Sessions) was added as a cosponsor of S. 2767, a bill to repeal the authority of the Secretary of the Treasury to extend the Troubled Asset Relief Program.

S. RES. 316

At the request of Mr. Menendez, the name of the Senator from Nevada (Mr. Reid) was added as a cosponsor of S. Res. 316, a resolution calling upon the President to ensure that the foreign policy of the United States reflects appropriate understanding and sensitivity concerning issues related to human rights, ethnic cleansing, and genocide documented in the United States record relating to the Armenian Genocide, and for other purposes.

S. RES. 377

At the request of Mr. Rockefeller, the names of the Senator from Wyoming (Mr. Enzi), the Senator from North Dakota (Mr. Dorgan) and the Senator from Pennsylvania (Mr. Casey) were added as cosponsors of S. Res. 377, a resolution designating December 6, 2009, as “National Miners Day.”

AMENDMENT NO. 2785

At the request of Mr. Coburn, the names of the Senator from Oklahoma (Mr. Inhofe) and the Senator from North Carolina (Mr. Burr) were added as cosponsors of amendment No. 2785 proposed to S. 1963, a bill to amend title 38, United States Code, to provide assistance to caregivers of veterans, to improve the provision of health care to veterans, and for other purposes.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mrs. Murray (for herself and Mr. Franken):

S. 2800. A bill to amend title VII of the McKinney-Vento Homeless Assistance Act to provide education for homeless children and youths, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

Mrs. Murray. Mr. President, I rise today to talk about legislation that I introduced with Senator Franken today that is essential to the academic success of millions of vulnerable children and youth.

The Educational Success for Children and Youth Without Homes Act responds to the growing crisis of homelessness in our Nation. The legislation will help homeless children and youth thrive in school, despite the constant moves, trauma, and loss associated with homelessness.

This legislation is needed now more than ever. The economic downturn and foreclosure crisis have had a significant impact on homelessness. Public schools reported a 17-percent increase in the number of homeless students in 2007. In Washington State, the number of homeless students has increased dramatically. For example, the number of homeless students enrolled in Whatcom County schools increased by 66 percent over the past 2 years; in Evergreen Public Schools, there has been a 56-percent increase over the past 2 years. This fall, many schools face a veritable tidal wave of homelessness. Over one million children and youth are now homeless in our Nation.

The recession has contributed to homelessness among students: children who are homeless with their families, and youth who are homeless on their own. This reality was brought starkly to light in the recent New York Times series about runaway and homeless youth. The series found a 40-percent increase in the number of homeless youth living on their own last year, more than double the number in 2003. In conclusion, that “Foreclosures, layoffs, rising food and fuel prices and inadequate supplies of low-cost housing have stretched families to the extreme, and those pressures have trickled down to teenagers and preteens.”

School offers homeless children and youth structure, normalcy, support, and hope—it is a place where they can obtain the skills that they will need to avoid poverty and homelessness as adults. Yet these students face great educational challenges. High mobility, precarious living conditions, and severe poverty combine to create major barriers to school enrollment and regular attendance. Many homeless children and youth lack basic supplies and a reasonable environment in which they can do homework. As a result of their circumstances, homeless students often perform below their peers in math and reading and are more likely to be held back.

We must do more to assist these students so they do not continue to be left behind. The Educational Success for Children and Youth Without Homes Act of 2009 would do just that. The bill strengthens the McKinney-Vento Act’s Education for Homeless Children and Youth program. It makes a strong law even stronger by reinforcing and expanding the law’s key provisions: school stability, enrollment, and support for academic achievement.

This legislation will enhance the right of homeless children to stay in the same school, so that children who have lost their homes do not also lose their schools. It will assist schools in meeting the challenges of transporting homeless students by increasing the authorized funding level and allowing other Federal funds for educating low-income students to be used for homeless transportation. When staying in the same school is not possible, or not in a child’s best interest, the legislation will help the student make a seamless transition to a new school.

This bill will help students like Kyle, a 4th-grade student in Spokane. Due to the instability of homelessness, Kyle moved around with his family most of his life. In fact, he moved eleven times. There were large gaps where he had not gone to school at all, because of his family’s frequent moves. Yet although Kyle moved eleven times, the homeless education program in Spokane was able to keep him stable in one school. Because he had the opportunity to attend one school consistently, the school district was able to determine that his academic and behavioral struggles were caused by more than just homelessness. A recent evaluation revealed that he was nearly deaf in both ears. He now has hearing aids in both ears and told his teacher:
I can hear now, and I am being good. I want to be a crossing guard.

Yet many more children like Kyle are not receiving the assistance they need due to lack of funding. In fact, only 9 percent of school districts are able to receive funding through the McKinney-Vento program currently. This legislation would increase the authorized funding level, so that more school districts can participate in the homeless education program and reach more children and youth experiencing homelessness.

One of the most successful features of the McKinney-Vento program is the requirement for every school district to designate a liaison for homeless children and youth. Liaisons identify homeless students, ensure their enrollment and attendance, and connect them to community resources. Liaisons are the backbone of this program, the unsung heroes who have become a lifeline for children and youth in crisis. Yet they too do not have the capacity to carry out their required duties; they wear many hats and struggle to meet the growing demands of this population. As a result, too many homeless children and youth are falling through the cracks and missing out on school. The Educational Success for Children and Youth Without Homes Act will strengthen the critical position of homeless liaison by ensuring that liaisons have the time, resources, and training to fulfill their mandated duties.

The Educational Success for Children and Youth Without Homes Act also recognizes the unique needs of certain groups of homeless children; preschool-aged homeless children, and unaccompanied homeless youth.

Young children who are homeless have higher rates of developmental delays and other problems that set them back as they start out life, yet they face numerous barriers to participating in early childhood programs. They miss out on services that can mitigate the harmful effect of homelessness on their development. This legislation will increase homeless children’s participation in preschool programs by requiring public preschool programs to identify and prioritize homeless children for enrollment, and to develop the capacity to serve all identified homeless children.

Unaccompanied youth struggle to go to school without the basic necessities of life or a parent to guide them. We must assist unaccompanied homeless youth to overcome the unique educational challenges related to being without a home and without a parent or guardian. This legislation will help ensure that unaccompanied homeless youth have the supports necessary to stay in school, graduate with their peers, and move on to a brighter future.

The history of litigation under the McKinney-Vento Act makes clear that we must do a better job helping educators learn about homelessness and support them in implementing the law. To this end, the legislation provides funding for technical assistance and training, and requires participation in professional development activities.

I am pleased to be joined by Senator Franken in cosponsoring this legislation to assist homeless students, and I am honored to cosponsor Senator Franken’s legislation, the Fostering Success in Education Act, to assist students who are in foster care. These bills recognize the similarities, and the differences, of students who are homeless and those who are in foster care. It is our intention to work with our Senate colleagues to ensure that children and youth who are currently served through the McKinney-Vento Act under the category of “awaiting foster care placement” will be transitioned to the Fostering Success in Education program, so that their unique needs may be best met.

As we look forward to the reauthorization of the Education for All Handicapped Children Act and the Secondary Education Act, we must recognize that children who do not know where they will sleep at night, or where their next meal will come from, face far greater challenges than simply remembering their homework. We must acknowledge that children who bounce between schools with each change of residence have little hope of taking advantage of even the best school programs. The most qualified teacher, or the most exceptional math reading program will not benefit children who are not enrolled in school, not attending regularly, and not assisted to overcome the barriers caused by homelessness. The Educational Success for Children and Youth Without Homes Act builds upon the proven successes of the McKinney-Vento Act’s Education of Homeless Children and Youth program, while addressing remaining challenges. It is critical legislation that will help ensure that the homeless children who do not become the homeless adults of tomorrow.

Mr. FRANKEN (for himself and Mrs. MURRAY):

S. 2801. A bill to provide children in foster care with school stability and equal access to educational opportunities; to the Committee on Health, Education, Labor, and Pensions.

Mr. FRANKEN. Mr. President, a quality education can be a positive counterweight to the abuse, neglect, and instability that children in foster care have experienced. That is why Senator Murray and I are introducing the Fostering Success in Education Act. The act builds on previous Federal efforts to increase the school stability and success of foster children.

The very placement of children in foster care has deprived many children of their opportunity to obtain a decent education. The primary reason is that children in foster care frequently move between foster homes, and often change schools when they move. Research shows that students lose 4 to 6 months of educational progress each time they change schools. It therefore becomes nearly impossible for foster children—who change schools multiple times—to make significant educational progress.

Moreover, foster children often change schools in the middle of the school year. When this happens, it is hard for them to catch up with their classmates, since they didn’t learn the material their classmates studied earlier in the year.

Because different schools offer different courses, it is also difficult for foster children to transfer their course credits from prior schools after they move. Many foster children therefore end up repeating courses and even grades.

But what is even more disturbing is that foster children are often segregated from other students, and inappropriately labeled with special needs. Many foster children end up in group foster homes and residential treatment facilities. At these separate schools, foster children typically receive a subpar education, making it difficult for them to transition smoothly to regular public schools later on.

As a result of all these challenges, many foster children fail behind their peers in school, lose hope, and ultimately drop out. Consider, for example, the school experience of Carrie, a 19 year-old young woman in Minnesota, who was placed in foster care in eighth grade. When Carrie moved to her first foster home, she had to transfer to a new school. Being uprooted from her family was difficult enough, but she also had to cope with the transition to her new school—just when she most needed the support of her friends and teachers at her old school. Moreover, because she changed schools in the middle of the school year, she found it difficult to keep up with her classmates in her new school.

There was no need to add further instability to Carrie’s life by making her change schools. Her old school—the school that she had attended since kindergarten—was just 20 minutes away from her foster home. It would have been perfectly reasonable to transport Carrie back to that school.

Over her next 5 years in foster care, Carrie ended up 7 moving between 7 different foster care placements and schools. The schools where she spent most of her time in high school separated her from other children in her community, and offered her a low-quality education. For example, in ninth grade, Carrie attended a school at a residential treatment facility, where her education consisted of sitting in a classroom with children as young as six years old, filling out simple worksheets with little help from an instructor. Given the multiple educational disruptions Carrie experienced, it is not surprising that she believes she left high school with only a ninth grade education.

Unfortunately, Carrie’s school experience is not unique. Many foster children in Minnesota, and across the
country, have experienced a similar pattern of moving between multiple schools, wasting time in segregated schools, and leaving school without much to show for all their years of education.

Last year, Congress decided that it was time to do something about this situation. Congress enacted the Fostering Connections to Success Act, a child welfare law that, among other things, requires child welfare agencies to collaborate with local education agencies to improve the school stability of foster children.

Child welfare agencies, however, can’t go it alone. To fulfill the vision of the Fostering Connections Act, they need the full cooperation of State and local education agencies.

That is why Senator MURRAY and I have decided to place requirements on State and local education agencies that mirror those required of child welfare agencies in the Fostering Connections Act. For example, our bill requires State and local education agencies to collaborate with child welfare agencies to provide foster children who move to new school districts with the right to attend their schools of origin—or, in other words, the right to attend their former schools or the schools they attended before they were placed in foster care.

If Carrie had this right when she was placed in foster care, she would have been able to remain in the school she had attended since kindergarten. When it’s not in the best interest of particular foster children to remain in their schools of origin, our bill requires State and local education agencies to work with child welfare agencies to enroll foster children immediately in new schools. This is an important element of our bill because foster children often spend weeks out of school as a result of enrollment delays.

In addition, our bill provides funding to help school districts and child welfare agencies address the educational needs of foster children, such as funding to provide foster children with transportation back to schools in their former school districts.

Finally, our bill clarifies that foster children have a right to the same educational opportunities as other children in their community. This means, for example, that foster children cannot be separated in schools only on the misguided belief that foster children cannot fit in at a regular public school.

In addition to working with Senator MURRAY on the Fostering Success in Education Act, we have collaborated on a related bill—the Educational Success for Children and Youth Without Homes Act, which Senator MURRAY introduced earlier today. The Educational Success for Children and Youth Without Homes Act will improve the educational stability of homeless children, who, like foster children, face significant educational challenges because they often move between school districts. While there are many similarities between the protections provided to homeless and foster children in our bills, our bills also address the unique circumstances of each group.

I am grateful to Carrie, and the many other foster and homeless youth who have bravely spoken out about their difficult school experiences. Their efforts will help prevent other children entering foster care or experiencing homelessness in the future from suffering similar situations.

I believe it is time that we listen to these youth and take steps to ensure that we don’t deprive homeless and foster children of their right to an equal education. Senator MURRAY and I therefore plan on working hard in the coming months to achieve the reforms we lay out in the bills we’re introducing today, and I would urge my colleagues to support both of these important bills.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the text of the bill was ordered to be printed in the RECORD, as follows:

TITLe I—EDUCATIONAL RIGHTS FOR CHILDREN IN FOSTER CARE

Subtitle A—Required Educational Rights, Protections, and Services for Children in Foster Care

Sec. 101. Required educational rights, protections, and services for children in foster care.

Sec. 102. Remedies; rule of construction.

Sec. 103. Conforming amendments.

Subtitle B—State Foster Care and Education Plan Grants

Sec. 111. State foster care and education plan requirements and grants.

Sec. 112. Subgrant.

Sec. 113. Responsibilities of the Secretary.

Sec. 114. Authorization of appropriations.

TITLe II—SOCIAL SECURITY ACT AMENDMENTS

Sec. 201. Social Security Act amendments.

SEC. 2. FINDINGS; SENSE OF CONGRESS.

(a) FINDINGS.—Congress makes the following findings:

(1) Educational success is vital to every young person’s well be in successful transition to adulthood, and economic stability.

(2) At the end of fiscal year 2007, approximately 500,000 children were in foster care in the United States, with nearly 800,000 children having spent at least some time in foster care in the United States during the year.

(3) Numerous studies have demonstrated that children in foster care fall behind the general student population with respect to test scores, graduation rates, and successful transitions to postsecondary education.

(4) Only one-third of high school students in foster care graduate on time and only 3 percent of such students graduate from college.

(5) On average, children in foster care move to new foster care placements 2 times per year, and often change schools when they move.

(6) Studies indicate that with each school move, children, on average, fall 4 to 6 test points behind their classmates. Because foster children often change schools multiple times, it is difficult for them to make significant educational progress.

(7) Children in foster care are frequently denied the ability to remain in the same school as a result of changes in their living situation.

(8) In addition, children in foster care who are required to change schools are frequently denied immediate enrollment in a new school, which results in detrimental disruptions to their education.

(9) Moreover, the enrolling school frequently does not have access to the child’s complete and accurate education records, which often results in detrimental placement in inappropriate classes and educational settings.

(10) When foster children change schools, they often have difficulties transferring credits from previous schools and meeting the new set of graduation requirements in their new school.

(11) In 2008, Congress enacted the Fostering Connections to Success and Increasing Adoptions Act of 2008 (Public Law 110–351), which requires, among other things, child welfare agencies to ensure that children in foster care remain in the same school after moving to a new placement or, when remaining in the same school is not in the child’s best interest, is enrolled in a new school immediately, and that the child’s education records are transferred promptly. While the Fostering Connections to Success and Increasing Adoptions Act of 2008 requires child welfare agencies to coordinate with local educational agencies, the local educational agencies must play a critical role in the process. Otherwise, the education provisions of the Act cannot be fully implemented.

(b) SENSE OF CONGRESS.—It is the sense of Congress that—

(A) address the unique needs of this population; and

(B) ensure school stability, immediate enrollment, and access to appropriate services; and

(C) such efforts will significantly increase the secondary school graduation rates and improve educational outcomes for children in foster care.

SEC. 3. PURPOSE.

The purpose of this Act is to ensure that the educational needs of children in foster care are addressed in a seamless and complete manner by—

(1) requiring the State educational agency of a recipient State to work together with the State child welfare agency to ensure that the educational needs of each child in foster care in the State are being met;

(2) requiring local child welfare agencies and local educational agencies of a recipient State to work together to ensure that the educational needs of each child in foster care in the State are being met;
(3) ensuring that issues related to stability in education, school attendance, and the proper handling of information, including education records and health records, are coordinated between schools and child welfare agencies; and
(4) ensuring that a coordinated process is utilized to address the best interest and needs of the child, with regard to school placements, school attendance, access to appropriate education services, and required supports, including the provision of transportation services to ensure school stability.

SEC. 4. DEFINITIONS.

In this Act:
(1) CHILD IN FOSTER CARE.—The term "child in foster care" means a child whose care and placement responsibility is delegated to a State, Tribal, or local educational agency or other State, Tribal agency that administers a State plan under part B or part E of title IV of the Social Security Act (42 U.S.C. 621 et seq.; 670 et seq.), without regard to whether foster care maintenance payments are made under section 472 of the Social Security Act (42 U.S.C. 672) on behalf of the child.
(2) COURT REPRESENTATIVE.—The term "court representative" means an individual appointed by a court to represent a child in a juvenile court dependency proceeding.
(3) EDUCATION DECISIONMAKER.—The term "education decisionmaker" means—
(A) a parent of a child in foster care; or
(B) an individual selected by the local educational agency to make education decisions for a child in foster care who is someone other than the child's parent.
(4) EDUCATION RECORDS.—The term "education records" means documents and other materials relating to a child's enrollment and education, including transcripts, reports, evaluations, and assessments maintained by a local educational agency.
(5) ELEMENTARY SCHOOL.—The term "elementary school" has the meaning given the term "local educational agency" in section 9101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801).
(6) ENROLLMENT.—The term "enrollment" means attending classes in a public school program, an elementary school, or secondary school and participating fully in the activities of such school or program.
(7) LOCAL CHILD WELFARE AGENCY.—The term "local child welfare agency" means, with respect to a child in foster care, the public agency in the local political subdivision where the child resides, or agencies of a tribe or tribal organization, that is responsible for the placement and care of the child.
(8) LOCAL EDUCATIONAL AGENCY.—The term "local educational agency" has the meaning given the term in section 9101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801).
(9) ORPHAN.—The term "parent" means a biological or adoptive parent or a legal guardian of a child, as determined under applicable State law.
(10) PLACEMENT.—The term "placement" means the current or proposed living situation for a child in foster care, which can include a group home or other congregate care setting.
(11) PUBLIC AGENCY.—The term "public agency" means any State or local government entity.
(12) PUBLIC PRESCHOOL PROGRAM.—The term "public preschool program" means a preschool program funded, administered, or overseen by a State educational agency, local educational agency, or other State agency.
(13) RECIPIENT STATE.—The term "recipient State" means a State that receives funds under part A of title IV of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6311 et seq.).
(14) SCHOOL OF ORIGIN.—The term "school of origin" means, with respect to a child in foster care, any of the following:
(A) The school in which the child was enrolled prior to entry into foster care.
(B) The school in which the child is enrolled when a change in foster care placement occurs or is proposed.
(C) Any school attended when last permanently housed, as such term is used in section 722(g)(3)(G) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11432(g)(3)).
(15) SCHOOL ATTENDANCE.—The term "school attendance area" has the meaning given the term in section 111(a)(2)(A) of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6313(a)(2)(A)).
(16) SCHOOL SELECTION DECISION.—The term "school selection decision" means a school selection decision as described in section 101(b)(4).
(17) SECONDARY SCHOOL.—The term "secondary school" has the meaning given the term in section 9101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801 et seq.).
(18) SECRETARY.—The term "Secretary" means the Secretary of Education.
(19) SPECIAL EDUCATION AND RELATED SERVICES.—The terms "special education" and "related services" have the meaning given such terms in part 1 of part B and part E of title IV of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 1400 et seq.).
(20) STATE.—The term "State" means each of the 50 States, the District of Columbia, and the Commonwealth of Puerto Rico.
(21) STATE CHILD WELFARE AGENCY.—The term "State child welfare agency" means the State agency responsible for administering the programs authorized under subpart I of part B and part E of title IV of the Social Security Act (42 U.S.C. 621 et seq.; 670 et seq.).
(22) STATE EDUCATIONAL AGENCY.—The term "State educational agency" has the meaning given the term in section 9101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801).

SEC. 5. REGULATIONS.

Not later than 60 days after the date of enactment of this Act, the Secretary shall develop, issue, and publish in the Federal Register a notice of proposed rulemaking to implement the provisions of this title. The Secretary shall issue, amend, and repeal any of regulations promulgated under this title shall comply with section 553 of title 5, United States Code.

SEC. 6. EFFECTIVE DATE.

Except as otherwise provided, this Act and the amendments made by this Act shall take effect on the date of enactment of this Act, except that title II and the amendments made by such title shall apply with respect to recipient States that receive funds under part B of title I of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6311 et seq.) on or after the date of enactment of this Act.

TITLE I—EDUCATIONAL RIGHTS FOR CHILDREN IN FOSTER CARE

Subtitle A—Required Educational Rights, Protections, and Services for Children in Foster Care

SEC. 101. REQUIRED EDUCATIONAL RIGHTS, PROTECTIONS, AND SERVICES FOR CHILDREN IN FOSTER CARE.

(a) RIGHTS OF CHILDREN IN FOSTER CARE.—Each recipient State shall ensure that each child in foster care in the State has the following rights:

(1) SCHOOL ATTENDANCE.—(A) School Year.—A child in foster care shall have the right to enroll in, or continue to enroll in, any of the child's schools of origin when the child is placed in foster care and during all subsequent changes in placement (including when the child returns home, as required under subparagraph (B)), it is determined that school selection decision process that it is in the child's best interest to be immediately enrolled in a different school.

(b) TREATMENT AS RESIDENT.—In the case of a child in foster care for whom the child welfare case is closed as a result of the child returning home or achieving another permanency outcome during a school year:

(i) the child shall be entitled to complete the school year in the school that the child is attending unless the entity making the school selection decision determines that a change in schools is in the child's best interest,

(ii) necessary transportation to the current school shall be arranged and funded by the local educational agency in which the current school is located.

(c) RESPONSIBILITY OF LOCAL EDUCATIONAL AGENCY.—Except as otherwise provided, this Act and the amendments made by this Act shall apply with respect to recipient States that receive funds under subtitle A, and the amendments made by this Act shall take effect on or after the date of enactment of this Act, the Secretary shall determine the provisions of this title. The Secretary shall be treated by the local educational agency serving such school as if the child resides in the school district and is entitled to all school privileges.

(d) IMMEDIATE ENROLLMENT.—If it is determined through the school selection process that it is not in the best interest of a child in foster care to attend a school of origin, or if such school selection decision determines that the child shall have the right to be immediately enrolled in a new school in the child's school attendance area, regardless of the status of records normally required for enrollment such as previous academic records, medical or immunization records, proof of residency, or other documentation or requirements.

(e) RECORDS.—

(A) IN GENERAL.—The education records of a child in foster care shall be:

(i) maintained so that the records are available, in a timely fashion, when a child enters a new school or school district;

(ii) immediately sent to the enrolling school as complete as possible, even if the student owes fees or fines or was not withdrawn from the previous school in conformance with local withdrawal procedures; and

(B) RECORDS FOR ACADEMIC DECISIONS.—The education records needed for academic placement decisions and decisions regarding the transfer of school credits for a child in foster care shall be released immediately to an enrolling school by facsimile or other available electronic means.

(f) EQUAL ACCESS.—Each child in foster care shall have equal access to the same education and opportunities as other students attending the school or school district, including:

(i) being registered in the school or school district immediately upon registration; and

(ii) being given the same opportunities, access, and services needed to meet the challenging educational offerings, including—

(a) having the same opportunities, access, and services needed to meet the challenging academic achievement standards under section 1111(b)(1) of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6311(b)(1)) that are provided to other students;

(b) receiving educational services and transportation services that are comparable to the services offered other children in the child's school;

(c) having—

(i) equal access to the full range of educational offerings, including:

(A) services under title I of such Act (20 U.S.C. 1601 et seq.);

(ii) publicly funded early childhood programs and public preschool programs;
public education as is provided to other children, after the effective date of this Act until such review and revision is undertaken. (ii) the parents and education decisionmaker shall be informed of the requirements of this title and the provisions of parts B and E of title IV of the Social Security Act (42 U.S.C. 670 et seq.) relating to the educational needs of children in foster care.

C. SPECIAL RULE.—In the case of a State that receives a grant under section 111 in an amount that is more than the minimum allotment described in section 111(b)(1)(B), the requirements of this paragraph for the State shall not be the same individual who is assigned the role of State Coordinator for purposes of the programs supported under such Act (42 U.S.C. 6432 et seq.).

D. RESPONSIBILITIES.—The responsibilities of a coordinator described in subparagraph (A) shall include, at minimum—

- (i) ensuring that the requirements of this title and clauses (i) and (ii), (iii), and (iv) of section 7751(v)(ii)(II) of the Social Security Act (42 U.S.C. 675(1)(G)(ii)(II)) are carried out;
- (ii) gathering and making public information on the problems children in foster care face in gaining access to public preschool programs and schools;
- (iii) monitoring the progress of the State and local educational agencies in addressing any problems or difficulties in meeting the requirements of this title;
- (iv) ensuring the success of the programs under this title;
- (v) providing technical assistance to local educational agencies and local child welfare agencies on how to comply with this title;
- (vi) ensuring that the implementation of this title and the educational outcomes of children in foster care and reporting such information to the appropriate State officials and to the Secretary;
- (vii) ensuring effective implementation of a dispute resolution procedure, as described in paragraph (5), and a complaint management system, as described in paragraph (6);

3. FOSTER CARE LIASON.—

A. IN GENERAL.—The State educational agency shall ensure that each local educational agency and local child welfare agency has a foster care liaison with sufficient capacity, resources, and time to fulfill the requirements of this section.

B. RESPONSIBILITIES.—The foster care liaison shall ensure, at minimum, that—

- (i) each child in foster care served by the local educational agency or local child welfare agency is identified for purposes of this title;
- (ii) enrolled in the appropriate preschool program or elementary or secondary school, or by school selection decision made for the child; and
- (iii) has a full and equal opportunity to succeed in the child’s school program and receive appropriate education, for which the child is eligible, including—
  - (aa) special education and related services and protections under the Individuals with Disabilities Education Act (20 U.S.C. 1400 et seq.); and
  - (bb) programs under title I of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6301 et seq.); and
  - (cc) English as a Second Language programs, including programs under title III of such Act (20 U.S.C. 6801 et seq.); and
  - (dd) in early childhood programs and preschool programs;

- (iii) N O TIFICATION OF FOSTER CARE LIASON.—In the case of a child in foster care in a school served by the local educational agency and local child welfare agency under this Act, the State shall be notified of the foster care liaison described in paragraph (5). (B) ENTITIES MAKING SCHOOL SELECTION DECISIONS.—The State educational agency shall ensure that the State and local education agencies and local child welfare agencies have a foster care liaison with sufficient capacity, resources, and time to fulfill the requirements of this title; and

- (ii) the State child welfare agency or the local educational agency shall notify the foster care liaison described in paragraph (5). (C) INITIATING A SCHOOL SELECTION DECISION.—

A. IN GENERAL.—Upon a request made in accordance with subparagraph (C), the appropriate entity described in subparagraph (B) shall ensure that each child in foster care is enrolled in a school that serves the child’s school attendance area unless—

- (i) the child has been determined to be a child in foster care because of neglect, abandonment, or abuse; and
- (ii) the child’s parents or legal guardians or the court in which the child resides or in the case of a child in foster care, the State agency responsible for the child’s welfare or the local educational agency designated by the court shall notify the foster care liaison described in subparagraph (C) of the child’s enrollment in a school under this Act.

B. NO DELAY.—Nothing in this subsection shall be construed to permit a State or local educational agency to delay implementation of this title for the purpose of ensuring that the child attends a school that serves the educational needs of the child in foster care.

C. DEPENDENCY COURT DECISION.—If the court believes that a child’s education should be affected by the court’s decision, it may do so by contacting the appropriate foster care liaison described in clause (ii).

D. EXCEPTION.—If the local educational agency has not initiated the school selection process in the case of a child in foster care with a disability, the child’s parents or legal guardian may do so by contacting the appropriate foster care liaison described in clause (ii).
makes a school selection decision for such child, or appoints another person to initiate or make a school selection decision, the court’s determination shall be binding on all parties to the State educational agency, the local educational agency, and the appropriate local educational agency.

(E) SOURCES OF INFORMATION; FACTORS.—(i) SOURCES OF INFORMATION.—The entity making the school selection decision for a child in foster care shall consider information and factors provided by—

(I) the State child welfare agency, local child welfare agency, or the State educational agency, local educational agency, or other public agency; and

(ii) An individual who have knowledge about the child’s education, including the child and the parent, educational decisionmaker, foster parent, court representative, and teachers of the child.

(ii) INFORMATION AND FACTORS.—The information and factors described in clause (i) shall include—

(I) the harmful impact of school mobility on the child’s academic progress, achievement, and social and emotional well-being;

(II) the age of the child;

(III) the impact on the child’s commute to school may have on the child’s education or well-being;

(IV) personal safety issues, including safety as it relates to family violence;

(V) the child’s need for special instruction, including special education and related services, and where the needs can be met; or

(VI) the length of stay in foster care, placement type, and permanency plan for the child;

(VII) the time remaining in the school year;

(VIII) the placement of family members; and

(IX) the number of previous school changes;

(X) the child’s connection to the school of origin under section 475(1)(G)(ii)(II); and

(XI) the extent to which the educational program of the school of origin is appropriate, meets the child’s needs and interests, and nurtures the child’s talents; and

(XII) the availability of special programs, academically rigorous courses, and extra-curricular activities that are appropriate for the child’s grade level.

(F) CONSIDERATIONS.—An entity making a school selection decision under this paragraph shall consider the wishes of the child.

(G) SCHOOL PLACEMENT DURING DISPUTE.—If a dispute arises over the school selection decision, the child shall remain in the child’s current school until full resolution of the dispute, unless—

(I) the dependency court determines otherwise and selects a different school for the child;

(ii) the State child welfare agency or local child welfare agency with responsibility for the child determines that the child’s health or safety would be at risk if the child remained in such school prior to a determination made under subparagraph (A) and selects a different school for the child;

(iii) the local educational agency, the State agency that funds such programs and oversight agencies acting on behalf of a child in foster care request that the State investigate and correct violations of this subtitle in a timely manner on behalf of a child in foster care; or

(iv) the local child welfare agency with responsibility for the child determines that the child’s health or safety would be at risk if the child remained in such school prior to a determination made under subparagraph (A) and selects a different school for the child.

(H) TRANSPORTATION.—In the case of a dispute under this paragraph regarding a child in foster care, the local educational agency where the child is attending school pending the resolution of the dispute, as determined under subparagraph (C), shall collaborate with the local child welfare agency to ensure transportation service, as required under section 101(a)(6), for the child to such school, until the full resolution of the dispute in accordance with this paragraph.

(I) COMPLAINT MANAGEMENT SYSTEM.—Each State shall maintain a complaint management system by which individuals and organizations acting on behalf of a child in foster care can request that the State investigate and correct violations of this subtitle in a timely manner on behalf of a child in foster care; or a group of children in foster care.

(J) SCHOOL READINESS FOR CHILDREN IN FOSTER CARE.—(A) STATE AND LOCAL EDUCATIONAL AGENCIES.—Each State educational agency and local educational agency shall ensure that public preschool programs funded, administered, or overseen by such agency—

(I) identify and prioritize preschool-aged children in foster care; or

(ii) provide preschool-aged children in foster care with the rights described in sub-paragraph (a), and comply with the requirements of this section with respect to such children, except that such programs—

(I) shall not be required to enroll a child in foster care immediately in a public preschool program that is operating at full capacity when enrollment is sought for the child, unless otherwise required by State law;

(ii) shall not be subject to the dispute resolution procedures of the State educational agency or local educational agencies, but shall

(aa) ensure that all of the dispute resolution procedures available through such programs and the State agency that funds, administers, or oversees such programs are accessible to the educational decisionmaker, court representative of a child in foster care, and a representative from the local child welfare agency; and

(bb) provide such individuals with a written explanation of their dispute and appeal rights; and

(iii) shall not be subject to the transportation services for children in foster care and shall, to the maximum extent practicable, arrange or provide transportation for children in foster care to attend public preschool programs, including the children’s school of origin;

(iii) shall provide preschool-aged children in foster care for enrollment and increase such children’s enrollment and attendance in public preschool programs, including through activities described in clauses (I) through (V) of subparagraph (A)(ii); and

(iv) review the educational and related needs of children in foster care and the children’s families in the State, in coordination with the coordinator described in paragraph (2), and develop policies and practices to meet identified needs.

(K) CHARTER ORGANIZATIONS.—For the purposes of applying this paragraph, a reference to a school shall be deemed to include a public preschool program.

(L) SHARING INFORMATION.—(A) IN GENERAL.—The State educational agency and local educational agency shall

(1) reserving spaces in public preschool programs for children in foster care;

(II) conducting targeted outreach to local child welfare agencies and foster care programs;

(iii) waiving application deadlines;

(iv) providing ongoing professional development for staff regarding the needs of children in foster care; and

(v) developing capacity to provide all children in foster care in the area served by such agency.

(B) OTHER STATE AGENCIES.—In the case of public preschool programs that are not funded, administered, or overseen by the State educational agency or a local educational agency, the State agency that funds such public preschool programs shall—

(i) develop, review, and revise its policies and practices to reflect the enrollment, attendance, retention, and success of children in foster care in public preschool programs funded, administered, or overseen by such agency;

(ii) provide preschool-aged children in foster care with the rights described in subsection (a), and comply with the requirements of this subsection with respect to such children, except that such programs—

(I) shall not be required to enroll a child in foster care immediately in a public preschool program that is operating at full capacity when enrollment is sought for the child, unless otherwise required by State law;

(ii) shall be subject to the dispute resolution procedures of the State educational agency or local educational agencies, but shall

(aa) ensure that all of the dispute resolution procedures available through such programs and the State agency that funds, administers, or oversees such programs are accessible to the educational decisionmaker, court representative of a child in foster care, and a representative from the local child welfare agency; and

(bb) provide such individuals with a written explanation of their dispute and appeal rights; and

(iii) shall not be subject to the transportation services for children in foster care and shall, to the maximum extent practicable, arrange or provide transportation for children in foster care to attend public preschool programs, including the children’s school of origin;

(iii) shall provide preschool-aged children in foster care for enrollment and increase such children’s enrollment and attendance in public preschool programs, including through activities described in clauses (I) through (V) of subparagraph (A)(ii); and

(iv) review the educational and related needs of children in foster care and the children’s families in the State, in coordination with the coordinator described in paragraph (2), and develop policies and practices to meet identified needs.

(M) CHARTER ORGANIZATIONS.—For the purposes of applying this paragraph, a reference to a school shall be deemed to include a public preschool program.

(N) SHARING INFORMATION.—(A) IN GENERAL.—The State educational agency and local educational agency shall
review and eliminate any barriers to information-sharing with State child welfare agencies and local child welfare agencies, while continuing to protect the privacy interests of children, as required by Federal or State law.

(B) IMMEDIATE AVAILABILITY.—To ensure a child in foster care's immediate enrollment in a new school (including a preschool program), all education records of the child shall be made available in accordance with subsection (a)(4). A school sending education records shall so certify that the records are as complete and accurate as possible.

(C) COMPLIANCE WITH FERPA.—Education records of children in foster care shall be—

(i) maintained and provided to other schools in a manner consistent with section 449 of the General Education Provisions Act (commonly referred to as the “Family Educational Rights and Privacy Act of 1974”) (20 U.S.C. 1232g); and

(ii) provided to the child welfare agency or other child welfare system advocates in a manner that complies with such section.

(D) EXPEDITED TRANSFER.—Each foster care liaison described in paragraph (3) and coordinator described in paragraph (2) within a State shall work to expedite the transfer of education records of children in foster care.

(9) TRANSFER OF CREDITS; DIPLOMA.—

(A) IN GENERAL.—Each local educational agency of the State shall ensure that a child in foster care—

(i) is afforded opportunities to recover school credits lost due to placement instability while in foster care.

(B) ELIMINATING BARRIERS.—The State shall allow a child in foster care to—

(i) receive a secondary school diploma either from the school in foster care, as defined in section 4 of the Family Education Independence Act, or a school of origin; and

(ii) the written description of the programs, activities, services, and vouchers described in subparagraph (A); and

(ii) ensure that such programs, activities, services, and vouchers are coordinated with the local educational agency's role in providing guidance, information, and support to implement the education-related provisions of the plan.

(C) LOCAL EDUCATIONAL AGENCY ROLE.—Each local educational agency of the State shall—

(i) cooperate with the implementation of programs, activities, services, and vouchers described in subparagraph (A); and

(ii) ensure that such programs, activities, services, and vouchers are coordinated with the local educational agency's role in providing guidance, information, and support to implement the education-related provisions of the plan.

(F) EFFECTIVE DATE.—This paragraph shall apply with respect to locations that occur in whole or in part after the effective date of this Act.

(G) REMEDIES.—In a civil action against a State for a violation of this paragraph, remedies (including remedies both at law and in equity) are available for such a violation to the same extent as those remedies are available for such a violation in the civil action against any public entity other than a State.

(H) RULE OF CONSTRUCTION.—Nothing in this title shall be construed to restrict or limit the rights, procedures, and remedies available under—

(i) the Constitution;

(ii) the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11461 et seq.);

(iii) the Fostering Connections to Success andForever Adopted Act of 2008 (Public Law 110-315), or the amendments made by such Act;

(iv) section 444 of the General Education Provisions Act (20 U.S.C. 1232g); and

(v) any other Federal or State law protecting the rights of children in foster care.

2. SEC. 102. REMEDIES; RULE OF CONSTRUCTION. (a) JUDICIAL REMEDIES.—To carry out this section, each State educational agency and the local educational agencies of a recipient State shall collaborate with the State child welfare agency and local child welfare agencies of such State. The accountability provisions in section 402 of the Family Educational Rights and Privacy Act of 1974 (20 U.S.C. 1232g) shall apply to the implementation of the provisions of this section.

(b) IN GENERAL.—Any party aggrieved by a finding or decision made under paragraph (5) or (6) of section 101(b), or who otherwise believes a right provided under this Act has been violated, may bring a civil action in an appropriate district court of the United States.

SEC. 103. CONFORMING AMENDMENTS. (a) The Elementary and Secondary Education Act of 1965 (20 U.S.C. 6301 et seq.) is amended—

(i) in section 111(a)(2)(B) of such Act, by adding after subparagraph (A) the following paragraph:

(“L) ACCOUNTABILITY FOR CHILDREN IN FOSTER CARE.—The accountability provisions are applicable to such plans with respect to children in foster care, as defined in section 4 of the Fostering Success in Education Act, which are included in the accountability system as part of the plan, in accordance with paragraph (3)(C)(xii).”; and

(ii) in paragraph (14), by striking the period at the end and inserting “; and”;

(iii) by Amending—

(i) in subsection (b)(2), by adding after subparagraph (A) the following paragraph:

(“(L) ACCOUNTABILITY FOR CHILDREN IN FOSTER CARE.—The accountability provisions are applicable to such plans with respect to children in foster care, as defined in section 4 of the Fostering Success in Education Act, which are included in the accountability system as part of the plan, in accordance with paragraph (3)(C)(xii).”; and

(ii) in subsection (c), by Amending—

(i) in paragraph (4), by striking “and” at the end and inserting “, or”;

(ii) in paragraph (12), by striking “or” at the end and inserting “, and”;

(iii) in paragraph (13), by striking “or” at the end and inserting “, and”;

(iv) in paragraphs (14) and (15), by striking “or” at the end and inserting “, and”;

(v) in paragraph (16), by striking “or” at the end and inserting “, and”;

(vi) in paragraph (17), by striking “or” at the end and inserting “, and”;

(vii) in paragraph (18), by striking “or” at the end and inserting “, and”;

(viii) in paragraph (19), by striking “or” at the end and inserting “, and”;

(ix) in paragraph (20), by striking “or” at the end and inserting “, and”;

(x) in paragraph (21), by striking “or” at the end and inserting “, and”;

(xi) in paragraph (22), by striking “or” at the end and inserting “, and”;

(xii) in paragraph (23), by striking “or” at the end and inserting “, and”;

(xiii) in paragraph (24), by striking “or” at the end and inserting “, and”;

(xiv) in paragraph (25), by striking “or” at the end and inserting “, and”;

(xv) in paragraph (26), by striking “or” at the end and inserting “, and”;

(xvi) in paragraph (27), by striking “or” at the end and inserting “, and”;

(xvii) in paragraph (28), by striking “or” at the end and inserting “, and”;

(xviii) in paragraph (29), by striking “or” at the end and inserting “, and”;

(xix) in paragraph (30), by striking “or” at the end and inserting “, and”;

(xx) in paragraph (31), by striking “or” at the end and inserting “, and”;

(2) JURISDICTION.—The district courts of the United States shall have jurisdiction of actions brought under this title without regard to the amount in controversy.

(3) EFFECTIVE DATE.—This paragraph shall apply with respect to violations that occur in whole or in part after the effective date of this Act.

SEC. 104. REMEDIES.—In a civil action against a State for a violation of this paragraph, remedies (including remedies both at law and in equity) are available for such a violation to the same extent as those remedies are available for such a violation in the civil action against any public entity other than a State.

(b) RULE OF CONSTRUCTION.—Nothing in this title shall be construed to restrict or limit the rights, procedures, and remedies available under—

(i) the Constitution;

(ii) the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11461 et seq.);

(iii) the Fostering Connections to Success andForever Adopted Act of 2008 (Public Law 110-315), or the amendments made by such Act;

(iv) section 444 of the General Education Provisions Act (20 U.S.C. 1232g); and

(v) any other Federal or State law protecting the rights of children in foster care.
(iii) by adding at the end the following: 

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are receiving assistance under this subtitle; and
(iii) ensuring that the State is in compliance with the requirements under this title.
(B) STATE STRATEGIES.—A State child welfare agency shall collaborate with the State child welfare agency in carrying out the responsibilities under this paragraph.
(2) Plan submissions. (A) In general.—A State receiving a grant under this subtitle shall carry out the following activities:

(A) STAKEHOLDER COUNCIL.—(i) Establishment.—The State educational agency shall establish a Stakeholder Council (referred to in this paragraph as the “Council”) that meets publicly on not less than a semiannual basis.

(ii) MEMBERSHIP.—The members of the Council shall include, at a minimum—

(I) a designee from the State educational agency;

(II) a designee from the State child welfare agency; and

(III) individuals representing local educational agencies, local child welfare agencies, juvenile courts, court representatives, court appointed special advocates, children in foster care, foster parents, and parents.

(iii) DUTIES.—The Council shall—

(I) develop policies, practices, data, and other information regarding the implementation of this title;

(II) review and advise the State on the plans before submission or resubmission; and

(III) make recommendations regarding procedures and policies for implementing this title.

(2) Activities.—Each local educational agency in a State receiving a grant under this subtitle shall carry out the following activities:

(A) in general.—The State educational agency shall, in accordance with section 111(b)(2), award subgrants, on a competitive basis, to public agencies, including educational agencies and local child welfare agencies, that wish to collaborate with the State educational agency, the State child welfare agency, any other applicable State agency, and the Secretary on the status of implementation efforts, including an analysis of data collected; and

(B) identify significant barriers to compliance that are described in subsection (c)(3)(B);

(V) prepare and submit an annual report to the State educational agency, including—

(III) other barriers impeding the rights of a child in foster care;

(V) make recommendations regarding the application of this title to particular schools or school districts.

(B) MONITORING.—The State educational agency, in collaboration with the State child welfare agency, shall periodically monitor local educational agencies and other local agencies with responsibilities under this title to ensure compliance.

(f) LOCAL EDUCATIONAL AGENCY REQUIREMENTS.—Each local educational agency in a State receiving a grant under this subtitle shall meet the following requirements:

(1) IN GENERAL.—The local educational agency shall ensure, in coordination with the corresponding local child welfare agency, that children in foster care in the school district served by the local educational agency receive all of the rights described in section 101(a) for carrying out, at a minimum, all of the following:

(A) Ensuring that each child in foster care in the school district served by the local educational agency remains in a school of origin or is immediately enrolled in a new school, in accordance with the child’s best interest as required under section 101(a).

(B) Issuing written notice of the parents’ rights that have been provided to the parent, education decisionmaker, and court representative of the child.

(C) Providing the notice of the child’s rights to the local child welfare agency representative of the child, to the State and, in accordance with any decision made by the local educational agency regarding the rights under this title of a child in foster care, including—

(i) an explanation of the basis for the decision;

(ii) the right to appeal the decision; and

(iii) the right of the child to remain in the child’s current school while a dispute is pending.

(D) Ensuring compliance with this title by all schools served by the local educational agency.

(E) Identifying and removing any barriers that exist in schools served by the local educational agency, including—

(i) barriers identified in the plan under subsection (b)(3)(B); and

(ii) barriers to remaining or enrolling in a school of origin, or to enrolling promptly in a new school for a child in foster care if such enrollment is in the child’s best interest; or

(iii) other barriers impeding the rights of a child in foster care.

(F) Ensuring that the schools served by the local educational agency promptly transfer the school credits and partial school credits of children in foster care, and provide children in foster care with access to credit recovery programs or services.

SEC. 112. GRANTS.—

(a) IN GENERAL.—The State educational agency shall award grants under this section to public agencies, including—

(A) a designee from the State child welfare agency, and the Secretary on the status of implementation efforts, including an analysis of data collected; and

(B) identify significant barriers to compliance that are described in subsection (c)(3)(B);

(V) prepare and submit an annual report to the State educational agency, including—

(III) other barriers impeding the rights of a child in foster care;

(V) make recommendations regarding the application of this title to particular schools or school districts.

(b) PRIORITY.—In awarding subgrants under this section, the State educational agency shall give priority to the following applicants:

(A) Local child welfare agencies that have entered into agreements with local educational agencies to share responsibilities for providing, arranging, and paying for the education of children in foster care.

(B) Local educational agencies that have entered into such agreements with local child welfare agencies.

(C) Partnerships that—

(i) include not less than 1 local child welfare agency and not less than 1 local educational agency; and

(ii) have entered into such agreements.

(d) USE OF FUNDS.—A public agency, or a partnership of public agencies, receiving a grant under this section shall use funds received under this title of a child in foster care, including—

(A) funding of foster care liaison positions, as required under section 101(a).

(B) Documenting that written notice has been provided to the parent, education decisionmaker, and court representative of the child.

(C) Providing the notice of the child’s rights to the local child welfare agency representative of the child, to the State and, in accordance with any decision made by the local educational agency regarding the rights under this title of a child in foster care, including—

(i) an explanation of the basis for the decision;

(ii) the right to appeal the decision; and

(iii) the right of the child to remain in the child’s current school while a dispute is pending.

(D) Ensuring compliance with this title by all schools served by the local educational agency.

(E) Identifying and removing any barriers that exist in schools served by the local educational agency, including—

(i) barriers identified in the plan under subsection (b)(3)(B); and

(ii) barriers to remaining or enrolling in a school of origin, or to enrolling promptly in a new school for a child in foster care if such enrollment is in the child’s best interest; or

(iii) other barriers impeding the rights of a child in foster care.

(F) Ensuring that the schools served by the local educational agency promptly transfer the school credits and partial school credits of children in foster care, and provide children in foster care with access to credit recovery programs or services.

SEC. 113. RESPONSIBILITIES OF THE SECRETARY.—

(a) REVIEW OF STATE PLANS.—(1) IN GENERAL.—The Secretary of Education, in collaboration with the Secretary of Health and Human Services, shall review the plans submitted by States under section 111(c). If the plan meets the requirements of section 111 and is reasonably calculated to ensure that all children in foster care in the State receive all rights, benefits, and protections required by this title, the Secretary shall approve the plan.

(2) DISAPPROVAL.—(A) IN GENERAL.—If a plan does not meet the requirements described in paragraph (1), the Secretary shall disapprove the plan and provide the State educational agency with specific findings as to what needs to be corrected for approval.

(B) REVIEW PROCESS.—The Secretary shall promulgate regulations establishing a system by which States whose plans are disapproved can appeal such disapproval.

(c) SUBMISSION AND DISTRIBUTION.—The Secretary shall—

(1) require applications for grants under this subtitle to be submitted to the Secretary not later than the expiration of the 60-day period beginning on the date that funds are available for purposes of making such grants; and

(2) award such grants not later than the expiration of the 120-day period beginning on such date.

(d) DETERMINATION BY SECRETARY.—The Secretary, based on the information received from the States and information gathered by the Secretary under this subtitle and under section 101(b)(11), shall determine the extent to which State educational agencies are ensuring that each child in foster care has access to a free, appropriate public education.

(e) INFORMATION.—(1) COORDINATION.—The Secretary shall coordinate the information collection requirements under this subtitle and section 101(b)(12).
(2) DATA COLLECTION AND DISSEMINATION.—

The Secretary shall—

(A) directly or through grants, contracts, or cooperative agreements, periodically collect and disseminate data and information regarding the education of children in foster care; and

(B) require each State receiving a grant under this subtitle to annually provide—

(i) a report on the status of the education of children in foster care; and

(ii) such other data and information as the Secretary determines to be necessary and relevant to carry out this subtitle.

(2) EVALUATION AND DISSEMINATION.—The Secretary shall conduct evaluation and dissemination activities regarding programs designed to address the educational needs of elementary and secondary school students who are children in foster care.

(g) REPORT.—Not later than 4 years after the date of enactment of this Act, the Secretary shall prepare and submit to the Committee on Education and Labor and the Committee on Health, Education, Labor, and Pensions a report on the status of the education of children in foster care, which shall include information on—

(1) the educational outcomes of children in foster care; and

(2) the actions of the Secretary and the effectiveness of the programs supported under this title.

SEC. 114. AUTHORIZATION OF APPROPRIATIONS.

There is authorized to be appropriated to carry out the subtitle, $150,000,000 for each of the fiscal years 2011 through 2015.

TITLE II—SOCIAL SECURITY ACT AMENDMENTS

SEC. 201. SOCIAL SECURITY ACT AMENDMENTS.

(a) EDUCATIONAL STABILITY FOR FOSTER CARE CHILDREN.—Section 475(1)(G) of the Social Security Act (42 U.S.C. 675(1)(G)) is amended—

(1) in clause (1)—

(A) by striking “or” at the end of subclause (I) and inserting “and”;

and

(B) by striking subclause (II), and inserting in its place the following:

“(II) assures that the State agency has coordinated with the appropriate local educational agency to ensure that the child remains in the school in which the child is enrolled at the time of placement including, when necessary, the State agency arranging for, providing, or paying the cost of the transportation necessary to enable the child to remain in the school;”;

and

(2) by adding at the end the following:

“(III) assures by the State agency and the local educational agencies, if remaining in such school is not in the best interests of the child, to provide immediate and appropriate enrollment in a new school, with all of the educational records provided to the school; and

“(IV) assures by the State agency and local child welfare agencies that steps have been undertaken to collaborate with the State and local educational agencies to eliminate barriers to the educational stability, school enrollment, and educational success of the child.”

(b) REPORT PLAN REQUIREMENT.—Section 471 of the Social Security Act (42 U.S.C. 671(a)) is amended—

(1) in paragraph (32), by striking “and” after the semicolon;

(2) in paragraph (33), by striking the period at the end and inserting a semicolon; and

(3) by adding at the end the following:

“(34) provides that the State agency and local child welfare agencies will collaborate with the State and local educational agencies to collect the data and other information necessary for the implementation of the requirements of clauses (ii)(I), (ii)(II), (iii), and (iv) of subparagraph (G) of section 475(1) and the provisions of section 101 of the Fostering Success in Education Act; and

“(35) provides that the State agency and local child welfare agencies have identified staff within the agencies to be the point people with the State and local educational agencies related to educational issues, including the implementation of the requirements of clauses (ii)(I), (ii)(II), (iii), and (iv) of subparagraph (G) of section 475(1), as well as to coordinate with education agency liaisons and coordinators to implement the provisions of section 101 of the Fostering Success in Education Act.”.

By Mr. SPECTER:

S. 2805. A bill to amend the Food and Nutrition Act of 2008 to increase the amount made available to purchase commodities for the emergency food assistance program in fiscal year 2010; to the Committee on Agriculture, Nutrition, and Forestry.

Mr. SPECTER. Mr. President, I seek recognition to introduce legislation to deal with the pressing problem of hunger in the United States. The report of the Economic Research Service of the Department of Agriculture on Monday, November 16—3 days ago—disclosed some startling facts about hunger in America. There are at least 49 million Americans who experienced hunger last year. Among that number, 17 million were children, and 500,000 of those children were under the age of 6, which is a critical stage in child development.

The hunger problem hit disproportionately higher for Hispanics at 27 percent higher and African Americans at 26 percent higher. It is hard to find a sufficiently tough word to describe it—scandalous, outrageous, criminal, repugnant—that in this land of plenty, we should find Americans who are hungry. It is unacceptable to have people hungry anywhere in the world, but right here in our own backyard for this situation to exist is beyond the pale.

Having read the article on the 16th, I contacted the Secretary of Agriculture, Tom Vilsack, discussed the issue with him, and I am now introducing legislation which will add $250 million to the food banks to try to deal with this issue on an emergency basis. It would be my hope that this is the kind of legislation which could be passed very promptly—hopefully, before Christmas of this year during our current session—to take some immediate action to replenish the food banks so people in America are not hungry.

I am introducing this legislation providing for emergency food relief which is being undermined by a lack of access to proper nutrition, which is necessary for learning and academic achievement.

Fortunately, Congress has taken steps to address this important issue, appropriating in fiscal year 2010 $9.2 billion for the School Lunch Program and $3.8 billion for the Commodity Supplemental Food Program which provides nutrition assistance to mothers, children and the elderly. The economic stimulus package contained more than $20 billion for nutrition assistance. Yet, this USDA study shows us that more is needed.

That is why I am introducing legislation to double spending on The Emergency Food Assistance Program, or TFAP, from $250 to $500 million annually. Through TFAP, the USDA makes commodity and food purchases and then distributes nutrition assistance to states based on need. The numbers show us there is great need.

According to Feeding America, which operates 205 food banks nationwide and 10 in the Commonwealth of Pennsylvania, 99 percent of their food banks experienced an increase in demand during the month of September 2009 and 91 percent of food banks reported unemployment as a critical factor driving the increase in emergency food assistance. Unfortunately 51 percent of these food banks had to turn someone away in the last year. By doubling TFAP spending, Congress would significantly increase the amount of food being delivered to local food banks, ensuring that less Americans go hungry.
According to the Department of Agriculture, nearly 27 percent of the 356 billion pounds of available food in America is wasted each year. That is nearly 100 billion pounds of waste, when according to the charity Feeding America only 5 billion pounds of food is needed to eliminate hunger. In a country with such a food abundance, it is criminal that children go to bed hungry. Our country has an unmet need for food assistance providers in place. Government agencies, community food banks, food pantries, soup kitchens, shelters and churches all struggle to address the challenge of combating hunger. Let us provide them the resources they need. The legislation I am introducing today will do that and will stem the tide of hunger.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the text of the bill was ordered to be printed in the RECORD, as follows:

S. 205

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. FINDINGS.

Congress finds that—

(1) more than 1 in 7 households in the United States struggled to find enough to eat during 2008;

(2) poverty is the primary cause of food insecurity and hunger in the United States;

(3) the National Academy of the Economic Research Service of the Department of Agriculture, in the report of the National Academy of Sciences, Food Insecurity in the United States: 2008 (2009), found that in 2008, 17,000,000 households were food insecure, an increase from 13,400,000 households in 2007;

(4) the term “low food security” means people being unable to consistently get enough to eat and the term “very low food security” means people being hungry at various times over the year and being unable to eat because of lack of money to purchase food;

(5) the 17,000,000 food insecure households in the United States are home to 49,000,000 Americans, of whom—

(A) 17,000,000 are children, among whom nearly 5,000,000 in the developmentally critical years under the age of 6 are going hungry; and

(B) 12,000,000 adults and 5,200,000 children reported having severe hunger, possibly going days without eating;

(6) good nutrition is necessary for learning and academic achievement; and

(7) Black and Hispanic households experienced food insecurity at far higher rates (25.7 percent in the case of Black households and 26.9 percent in the case of Hispanic households) than the national average.

SEC. 2. AVAILABILITY OF COMMODITIES FOR THE EMERGENCY FOOD ASSISTANCE PROGRAM.

Section 2(a)(2) of the Food and Nutrition Act of 2009 (7 U.S.C. 2001a(2)) is amended—

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

(2) by redesignating subparagraph (C) as subparagraph (E); and

(3) in subparagraph (E) (as so redesignated)—

(A) by striking “each of fiscal years 2010 through 2012” and inserting “fiscal year 2012”; and

(B) by striking “paragraph (B)” and inserting “paragraph (D)”; and

(4) by striking after subparagraph (B) the following:

“(C) for fiscal year 2010, $500,000,000;

“(D) for fiscal year 2011, $250,000,000, as adjusted in accordance with subparagraph (E); and"

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 335—EXPRESSING THE SENSE OF THE SENATE THAT THE GOVERNMENT OF THE ISLAMIC REPUBLIC OF IRAN HAS SYSTEMATICALLY VIOLATED ITS OBLIGATIONS TO UPHOLD HUMAN RIGHTS PROVIDED FOR UNDER ITS CONSTITUTION AND INTERNATIONAL LAW

Mr. LEVIN (for himself, Mr. McCAIN, Mr. CLARKE, Mr. GRAHAM, Mr. LIEBERMAN, Mr. CORRIER, and Mr. NELSON of Florida) submitted the following resolution; which was considered and agreed to:

S. Res. 335

Whereas the 1979 Constitution of the Islamic Republic of Iran expressly guarantees certain human rights and fundamental freedoms, which encompass civil and political rights, along with economic, social, and cultural rights;

Whereas the Islamic Republic of Iran is a party to four major United Nations human rights treaties: the Convention on the Rights of the Child (which it ratified on July 13, 1994), the International Convention on the Elimination of All Forms of Racial Discrimination (which it ratified on August 29, 1968), and the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights (both of which it ratified on June 24, 1975);

Whereas the Government of Iran has routinely violated the human rights of its citizens, including—

(1) torture and cruel, inhuman, or degrading treatment or punishment, including flogging, and amputations;

(2) high incidence and increase in the rate of executions carried out in the absence of internationally recognized safeguards, including public executions and executions of juvenile offenders;

(3) stoning as a method of execution and persons in prison who continue to face sentences of execution by stoning;

(4) arrests, violent repression, and sentencing of women exercising their right to peaceful assembly, a campaign of intimidation against women’s rights defenders, and continuing discrimination against women and girls;

(5) increasing discrimination and other human rights violations against persons belonging to religious, ethnic, linguistic, or other minorities;

(6) ongoing, systematic, and serious restrictions of freedom of peaceful assembly and association and freedom of opinion and expression, including the continuing closures of media outlets, arrests of journalists, and the censorship or expression in online forums such as blogs and websites; and

(7) severe limitations and restrictions on freedom of religion and belief, including arbitrary detentions, and lengthy jail sentences for those exercising their right to freedom of religion or belief, including a provision in the proposed draft penal code that sets out a mandatory death sentence for apostasy, the abandoning of one’s faith;

Whereas, since March 9, 2007, Robert Levinson, a United States citizen, has been missing in the Islamic Republic of Iran, and the Government of Iran has provided little information on his whereabouts or assistance in ensuring his safe return to the United States;

Whereas Ja’far Kiani was publicly stoned to death in July 2007 in the Islamic Republic of Iran in contravention of an order from the Head of the Judiciary granting a temporary stay of execution;

Whereas, since May 2008, Reza Taghavi, a 71-year old Iranian-American, has been imprisoned without a trial or formal charges;

Whereas, on October 15, 2008, authorities in the Islamic Republic of Iran sentenced Esha Momeni, a graduate student at California State University, Northridge, for her peaceful activities in connection with the women’s rights movement in the Islamic Republic of Iran, and refused to grant her permission to leave Iran for 10 months following her release from prison in November 2008;

Whereas Iranian-American journalist Roxana Saberi was jailed in January 2009 and sentenced in a closed-door, one-hour trial to eight years in prison for charges of espionage before her release in May 2009;

Whereas, on June 19, 2009, the United Nations High Commissioner for Human Rights expressed concerns about the increasing number of illegal arrests not in conformity with the law and the illegal use of excessive force in responding to protests following the June 12, 2009, elections, resulting in at least dozens of deaths and hundreds of injuries;

Whereas the Government of Iran closed the Center for Defenders of Human Rights, headed by Nobel Peace prize winner Shirin Ebadi, in December 2008, and the Association of Iranian Journalists in August 2009, the country’s largest independent association for journalists;

Whereas, on August 1, 2009, authorities in the Islamic Republic of Iran began a mass trial of over 100 individuals in connection with election protests, most of whom were held incommunicado for weeks, in solitary confinement, with little or no access to their lawyers and families, many of whom showed signs of torture and drugging;

Whereas, in early October 2009, the judiciary of the Islamic Republic of Iran sentenced four individuals to death after the disputed presidential election, without providing the individuals adequate access to legal representation during their trials;

Whereas the Supreme Leader of Iran, Ali Khamenei, issued a statement on October 28, 2009, effectively criminalizing the use of the national election in the Islamic Republic of Iran this past June, further restricting the right to freedom of expression;

Whereas the Government of Iran does not allow independent nongovernmental associations and labor unions to perform their role in peacefully defending the rights of all persons;

Whereas, on November 4, 2009, security forces in the Islamic Republic of Iran used lethal force to disperse thousands of protesters, resulting in a number of injuries and arrests, in violation of international standards regarding the proportionate use of force against peaceful demonstrations;

Whereas, since March 2007, the Government of Iran has imposed restrictions on the travel of individuals, including artists and filmmakers since the recent elections, in reprisal for their political views or their criticism of the government;

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Whereas, on October 15, 2008, authorities in the Islamic Republic of Iran sentenced Esha Momeni, a graduate student at California State University, Northridge, for her peaceful activities in connection with the women’s rights movement in the Islamic Republic of Iran, and refused to grant her permission to leave Iran for 10 months following her release from prison in November 2008;

Whereas Iranian-American journalist Roxana Saberi was jailed in January 2009 and sentenced in a closed-door, one-hour trial to eight years in prison for charges of espionage before her release in May 2009;
human rights activist Emad Baghi, film director Jafar Panahi, and actress Fatemeh Motamed Arya; and

Whereas, according to Amnesty International, at least 346 people were known to have been executed in 2008, including eight juvenile offenders and two men who were executed by stoning; Now, therefore, be it

RESOLVED—
(1) calls for authorities in the Islamic Republic of Iran to respect the rights of the people of Iran to freedom of speech, press, religion, association, and assembly;
(2) condemns the Government of Iran’s human rights violations and calls on the Government of Iran to hold those responsible accountable;
(3) reminds the Government of Iran of its constitutional obligations under its 1979 Constitution and four international covenants to which it is a party;
(4) calls for the immediate release from detention of opposition figures, human rights defenders, journalists, and all others held for peacefully exercising their right to expression, assembly, and association;
(5) urges the Government of Iran to ensure that anyone placed on trial for committing acts that are clearly criminal acts benefits from all of his or her rights to a fair trial, including proceedings that are open to the public, the right to be represented by counsel, and guarantees that no statements shall be admitted into evidence that were shown to have been obtained through torture, inhumane, or degrading treatment;
(6) calls for the Government of Iran to ensure that those currently in detention are treated humanely, to provide detainees immediate access to their families, lawyers, and any medical treatment that may be needed, and calls for the Government of Iran to hold accountable those responsible for torture of detainees; and
(7) calls for authorities in the Islamic Republic of Iran, consistent with their obligations under the International Covenant on Civil and Political Rights, to guarantee all persons the “freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing, or in the form of art, or through any other media of his choice.”

SENATE RESOLUTION 356—CALLING UPON THE GOVERNMENT OF TURKEY TO FACILITATE THE REOPENING OF THE ECUMENICAL PATRIARCHATE’S THEOLOGICAL SCHOOL OF HALKI WITHOUT CONDITION OR FURTHER DELAY

Mr. CARDIN (for himself, Mr. BROWNBACK, Mr. REID, Mrs. SHAHEEN, Ms. SNOWE, and Mr. MENENDEZ) submitted the following resolution; which was referred to the Committee on Foreign Relations:

S. Res. 356

Whereas the Ecumenical Patriarchate is an institution with a history spanning 1,700 years, serving as the center of the Orthodox Christian Church throughout the world;

Whereas the Ecumenical Patriarchate sits at the crossroads of East and West, offering a unique perspective on the religious and cultural traditions of the world;

Whereas the title of Ecumenical Patriarch was formally accorded to the Archbishop of Constantinople by a synod convened in Constantinople in the 3rd century;

Whereas since November 1991, His All Holiness, Bartholomew I, has served as Archbishop of Constantinople, New Rome and Ecumenical Patriarch;

Whereas Ecumenical Patriarch Bartholomew I was awarded the Congressional Gold Medal in recognition of his outstanding and enduring contributions toward religious understanding and peace;

Whereas during the 110th Congress, 75 Senators, representing the majority of members of the Committee on Foreign Affairs of the House of Representatives wrote to President George W. Bush and the Prime Minister of Turkey expressing congressional concern, which continues today, regarding the absence of religious freedom for Ecumenical Patriarch Bartholomew I in the areas they controlled prior to their succession, the confiscation of the vast majority of Patriarchal properties, recognition of the international Ecumenicity of the Patriarchate, and the reopening of the Theological School of Halki;

Whereas the Ecumenical School of Halki, founded in 1844 and located outside Istanbul, Turkey, served as the principal seminary for the Ecumenical Patriarchate until its forcible closure by the Turkish authorities in 1971;

Whereas the alumni of this preeminent educational institution include numerous prominent Orthodox scholars, theologians, priests, bishops, and patriarchs, including Bartholomew I, the Patriarch of Constantinople;

Whereas the Republic of Turkey has been a participating state of the Organization for Security and Cooperation in Europe (OSCE) since signing the Helsinki Final Act in 1975;

Whereas in 1989, the OSCE participating states adopted the Vienna Concluding Document, committing to respect the right of religious communities to provide “training of religious personnel in appropriate institutions”;

Whereas the continued closure of the Ecumenical Patriarchate’s Theological School of Halki has been an ongoing issue of concern for the American people and the United States Congress and has been repeatedly raised by members of the Commission on Security and Cooperation in Europe and by United States delegations to the OSCE’s annual Human Dimension Implementation Meeting;

Whereas in his address to the Grand National Assembly of Turkey on April 6, 2009, President Obama stated that freedom of religion and expression lead to a strong and vibrant civil society that only strengthens the state, which is why steps like reopening Halki Seminary will send such an important signal inside Turkey and abroad; and

Whereas in a welcomed development, the Prime Minister of Turkey, Recep Tayyip Erdogan, met with the Ecumenical Patriarch on August 15, 2009, and, in an address to a wider gathering of minority religious leaders that day, concluded by stating, “We should not be of those who gather, talk, and disperse. A result should come out of this.”;

Whereas during his visit to the United States in November 2009, Ecumenical Patriarch Bartholomew II issued the order of the conclusion of the Theological School of Halki with President Obama, congressional leaders, and others; and

Whereas Prime Minister Erdogan is scheduled to make an official visit to Washington, D.C., in early December 2009; Now, therefore, be it

Resolved, That the Senate—
(1) welcomes the historic meeting between Prime Minister Recep Tayyip Erdogan and Ecumenical Patriarch Bartholomew I;
(2) urges the Government of Turkey to facilitate the Ecumenical Patriarchate’s Theological School of Halki without condition or further delay; and
(3) urges the Government of Turkey to address other longstanding concerns relating to the Ecumenical Patriarchate.

Mr. CARDIN. Mr. President, I was pleased to meet with the Ecumenical Patriarch, Bartholomew I, again last month during his visit to Washington. Together with the congressional leadership, we heard his impassioned call for support for the reopening of the Theological School of Halki, an institution that has come to symbolize many of the difficulties faced by the Patriarch, the remnant of the Greek community in Turkey and other religious and ethnic minorities in that country.

I had the pleasure to meet Bartholomew I during an official visit to modern-day Istanbul in 1998. He impressed me as a man of good will, anchored in his deep personal faith, seeking to promote understanding, justice and respect for the human rights and dignity of each individual and all communities. These very qualities that prompted the Congress a year earlier to award him the Congressional Gold Medal. Indeed, his leadership extends well beyond the borders of Turkey to the Orthodox community and the world.

The Ecumenical Patriarch repeatedly returned to the issue of the Halki Seminary in various meetings during his U.S. visit, including at this oval office meeting with President Obama. Earlier this year, several of my colleagues from the Commission on Security and Cooperation in Europe, which I chair, joined me in a letter to the President underscoring our longstanding concern over the continued closure of this unique institution. Founded in 1844, the Theological School of Halki, located outside modern-day Istanbul, served as the principal seminary for the Ecumenical Patriarchate until its forcible closure by the Turkish authorities in 1971. Currently, four alumni of this preeminent educational institution are numerous prominent Orthodox scholars, theologians, priests, and bishops as well as patriarchs, including Bartholomew I. Many of these scholars and theologians have served as faculty at other institutions serving Orthodox communities around the world.

While over the years there have been occasional indications by the Turkish authorities of pending action to reopen the seminary, to date all have failed to materialize. In a potentially promising development, Turkey’s Prime Minister, Recep Tayyip Erdogan, met with the Ecumenical Patriarch in August. In an address to a wider gathering of minority religious leaders that day, Erdogan concluded by stating, “We should not be of those who gather, talk, and disperse. A result should come out of this.”

I urge Prime Minister Erdogan to follow through on the sentiments of those remarks by actions that will facilitate the reopening of the Halki Seminary without condition or further delay. As Chairman of the Helsinki Commission,
I am particularly mindful of the fact that the continued closure of the Theological School of Halki stands in clear violation of Turkey’s obligations under the 1989 OSCE Vienna Concluding Document, which affirmed the right of religious communities to provide “training of religious personnel in appropriate institutions.”

At a time when Turkey is seeking to chart a new course, the resolution of this longstanding issue would not only be a demonstration of Ankara’s good will, but a President Obama mentioned in his address to the Turkish Grand National Assembly in April, will send such an important signal inside Turkey and beyond. I remain hopeful and encourage Prime Minister Erdoğan to act decisively and without condition on this matter before his upcoming visit to Washington in early December.

To underscore the importance attached to the reopening of the Theological School of Halki and our solidarity with the Ecumenical Patriarch, I am pleased to introduce a resolution on this issue together with Mr. Brownback, Mr. Reid, * * *

SENATE RESOLUTION 357—URGING THE PEOPLE OF THE UNITED STATES TO OBSERVE GLOBAL FAMILY DAY AND ONE DAY OF PEACE AND SHARING

Mr. INOUYE (for himself and Mr. REID) submitted the following resolution; which was referred to the Committee on the Judiciary:

S. Res. 357

Whereas in 2009, the people of the world suffered many calamitous events, including devastation from tsunamis, terror attacks, wars, famines, genocides, hurricanes, earthquakes, political and religious conflicts, disasters, poverty, and rioting, all necessitating global cooperation, compassion, and unity previously unprecedented among diverse cultures, faiths, and economic classes;

Whereas grave global challenges in 2010 may require creative and innovative problem-solving among citizens and nations on an even greater scale;

Whereas on December 15, 2000, Congress adopted Senate Concurrent Resolution 138, expressing the sense of Congress that the President of the United States should issue a proclamation each year calling upon the people of the United States and interested organizations to observe an international day of peace and sharing at the beginning of each year;

Whereas in 2001, the United Nations General Assembly adopted Resolution 56/2, which invited “Member States, intergovernmental and non-governmental organizations and all the peoples of the world to celebrate One Day in Peace, 1 January 2002, and every year thereafter”;

Whereas many foreign heads of State have recognized the importance of establishing Global Family Day, a special day of international unity, peace, and sharing, on the first day of each year; and

Whereas family is the basic structure of humanity, thus, we must all look to the stability and love within our individual families to create stability in the global community:

NOW, THEREFORE, be it

Resolved, That the Senate urgently requests—

(1) the people of the United States to observe Global Family Day and One Day of Peace and Sharing with appropriate activities stressing the need—

(A) to eradicate violence, hunger, poverty, and suffering; and

(B) to establish greater trust and fellowship among peace-loving countries and families everywhere; and

(2) American businesses, labor organizations, and faith and civic leaders to join in promoting appropriate activities for Americans and in extending appropriate greetings from the families of the United States to families in the rest of the world.

Mr. INOUYE. Mr. President, today, I am submitting a Senate resolution to observe Global Family Day, One Day of Peace and Sharing, and am pleased to be joined in this endeavor by Senator REID.

We are a global society, interconnected by highly efficient modes of communication and transportation. With continued advancements in technology, nations will become even more interdependent upon each other. For this reason, I will continue to support and advocate for world peace. This is not a lofty pursuit. I have great confidence that if nations use everything at their disposal, they can promote peaceful, diplomatic options instead of war.

AMENDMENTS SUBMITTED AND PROPOSED

SA 2786. Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) submitted an amendment intended to be proposed by him 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.

TEXT OF AMENDMENTS

SA 2786. Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) submitted an amendment intended to be proposed by him 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.

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 “Patient Protection and Affordable Care Act”.

(b) Table of Contents—The table of contents of this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS

Subtitle A—Immediate Improving Coverage

Part A—Individual and Group Market Reforms

"SUBPART II—Immediate Actions to Preserve and Expand Coverage

Sec. 1004. Effective dates.

Subtitle B—Quality Health Insurance Coverage for All Americans

PART I—HEALTH INSURANCE MARKET REFORMS

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

"SUBPART I—GENERAL REFORM

Sec. 2701. Fair health insurance premiums.

Sec. 2702. Guaranteed availability of coverage.

Sec. 2703. Guaranteed renewability of coverage.

Sec. 2704. Prohibition of preexisting condition exclusions or other discrimination based on health status.

Sec. 2705. Prohibiting discrimination against individuals and beneficiaries based on health status.

Sec. 2706. Non-discrimination in health care.

Sec. 2707. Comprehensive health insurance coverage.

Sec. 2708. Prohibition on excessive waiting periods.

PART II—OTHER PROVISIONS

Sec. 1251. Preservation of right to maintain existing coverage.

Sec. 1252. Rating reforms must apply uniformly to all health insurance issuers and group health plans.

Sec. 1253. Effective dates.

Subtitle D—Available Coverage Choices for All Americans

PART I—ESTABLISHMENT OF QUALIFIED HEALTH PLANS

Sec. 1301. Qualified health plan defined.

Sec. 1302. Essential health benefits requirements.

Sec. 1303. Special rules.

Sec. 1304. Related definitions.

PART II—CONSUMER CHOICES AND INSURANCE COMPETITION THROUGH HEALTH BENEFIT EXCHANGES

Sec. 1311. Affordable choices of health benefit plans.

Sec. 1312. Consumer choice.

Sec. 1313. Financial integrity.

PART III—STATE FLEXIBILITY RELATING TO SERVICE EXCHANGES

Sec. 1321. State flexibility in operation and enforcement of Exchanges and related requirements.
Sec. 3027. Extension of gainsharing demonstrations.

Sec. 3026. Community-Based Care Transition Program.

Sec. 3025. Hospital readmissions reduction program.

Sec. 3024. Independence at home demonstrations.

Sec. 3023. Hospital readmissions reduction program.

Sec. 3022. Medicare shared savings program.

Sec. 3021. Establishment of Center for Medicare and Medicaid Innovation within CMS.

Sec. 3020. National non-profit program on payment bundling.

Sec. 3019. Independence at home demonstration program.

Sec. 3018. Hospital readmissions reduction program.

Sec. 3017. Community-Based Care Transition Program.

Sec. 3016. Extension of gainsharing demonstrations.

Subtitle B—Improving Medicare for Patients care services.

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

Sec. 3101. Increase in the physician payment update.

Sec. 3102. Extension of the work geographic index floor and revisions to the practice expense geographic adjustment under the Medicare physician fee schedule.

Sec. 3103. Extension of exceptions process for Medicare therapy caps.

Sec. 3104. Extension of payment for the component of certain physician pathology services.

Sec. 3105. Extension of ambulance add-ons.

Sec. 3106. Extension of certain payment rules for long-term care hospital services and of moratorium on the establishment of certain hospitals and facilities.

Sec. 3107. Extension of the physician fee schedule mental health add-on.

Sec. 3108. Permitting physician assistants to order post-Hospital extended stay hospital services.

Sec. 3109. Exemption of certain pharmacies from accreditation requirements.

Sec. 3110. Part B special enrollment period for disabled TRICARE beneficiaries.

Sec. 3111. Payment for bone density tests.

Sec. 3112. Revision to the Medicare Improvement Fund.

Sec. 3113. Treatment of certain complex diagnostic laboratory tests.

Sec. 3114. Improved access for certified nurse-midwife services.

PART II—RURAL PROTECTIONS

Sec. 3121. Extension of outpatient hold harmless provision.

Sec. 3122. Extension of Medicare reasonable costs payments for certain clinical diagnostic laboratory tests furnished to hospital patients in certain rural areas.

Sec. 3123. Extension of the Rural Community Hospital Demonstration Program.

Sec. 3124. Extension of the Medicare-dependent hospital (MDH) program.

Sec. 3125. Temporary improvements to the Medicare inpatient hospital payment adjustment for low-volume hospitals.

Sec. 3126. Improvements to the demonstration project on community health integration models in certain rural counties.

Sec. 3127. MQIP study on adequacy of Medicare payments for health care providers serving in rural areas.

Sec. 3128. Technical correction related to critical access hospital services.

Sec. 3129. Extension of and revisions to Medicare rural hospital flexibility program.

PART III—IMPROVING PAYMENT ACCURACY

Sec. 3131. Payment adjustments for home health.

Sec. 3132. Hospice reform.

Sec. 3133. Improvement to Medicare disproportionate share hospital (DSH) payment.

Sec. 3134. Misvalued codes under the physician fee schedule.

Sec. 3135. Modification of equipment utilization factor for advanced imaging services.

Sec. 3136. Revision of payment for power-driven wheelchairs.

Sec. 3137. Hospital wage index improvement.

Sec. 3138. Treatment of certain cancer hospitals.

Sec. 3139. Payment for biosimilar biological products.

Sec. 3140. Medicare hospice concurrent care demonstration program.

Sec. 3141. Application of budget neutrality on a national basis in the calculation of the Medicare hospital wage index floor.

Sec. 3142. HHS study on urban Medicare-defined beneficiary payment.


Sec. 3201. Medicare Advantage payment.

Sec. 3202. Benefit protection and simplification.

Sec. 3203. Application of coding intensity adjustment during MA payment transition.

Sec. 3204. Simplification of annual beneficiary election periods.

Sec. 3205. Extension for specialized MA plans for special needs individuals.

Sec. 3206. Extension of reasonable cost contracts.

Sec. 3207. Technical correction to MA private fee-for-service plans.

Sec. 3208. Making senior housing facility demonstration permanent.

Sec. 3209. Authority to deny plan bids.

Sec. 3210. Development of new standards for certain Medigap plans.

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

Sec. 3301. Medicare coverage gap discount program.

Sec. 3302. Improvement in determination of Medicare part D low-income benchmark premium.

Sec. 3303. Voluntary de minimis policy for subsidy-eligible individuals under prescription drug plans.

Sec. 3304. Special rule for widows and widowers regarding eligibility for low-income assistance.

Sec. 3305. Improved information for subsidy-eligible individuals reassigned to prescription drug plans and MA–PD plans.

Sec. 3306. Funding outreach and assistance for low-income programs.

Sec. 3307. Improving formulaic requirements for prescription drug plans and MA–PD plans with respect to certain categories or classes of drugs.

Sec. 3308. Reducing part D premium subsidy for high-income beneficiaries.

Sec. 3309. Elimination of cost sharing for certain dual eligible individuals.

Sec. 3310. Reducing wasteful dispensing of outpatient prescription drugs in long-term care facilities under prescription drug plans.

Sec. 3311. Improved Medicare prescription drug plan and MA–PD plan complaint system.

Sec. 3312. Uniform exceptions and appeals process for prescription drug plans and MA–PD plans.


Sec. 3314. Including costs incurred by AIDS drug assistance programs and Indian Health Service in providing prescription drugs toward the annual out-of-pocket threshold under part D.

Sec. 3315. Immediate reduction in coverage gap in 2009.

Subtitle E—Health Care Quality Improvement

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

Sec. 3402. Temporary adjustment to the calculation of part B premiums.

Sec. 3403. Independent Medicare Advisory Board.

Subtitle F—Health Care Quality Improvement

Sec. 3501. Health care delivery system research; Quality improvement technical assistance.

Sec. 3502. Establishing community health teams to support the patient-centered medical home.

Sec. 3503. Medication management services in treatment of chronic disease.

Sec. 3504. Design and implementation of regionalized systems for emergency care.

Sec. 3505. Trauma care centers and service availability.

Sec. 3506. Program to facilitate shared decisionmaking.

Sec. 3507. Presentation of prescription drug benefit and risk information.

Sec. 3508. Demonstration program to integrate quality improvement and patient safety training into clinical education of health professionals.

Sec. 3509. Improving women’s health.

Sec. 3510. Patient navigator program.

Sec. 3511. Authorization of appropriations.

TITLE IV—PREVENTION OF CHRONIC DISEASE AND IMPROVING PUBLIC HEALTH

Subtitle A—Modernizing Disease Prevention and Public Health Systems


Sec. 4002. Prevention and Public Health Fund.

Sec. 4003. Clinical and community preventive services.

Sec. 4004. Education and outreach campaign regarding preventive benefits.

Subtitle B—Increasing Access to Clinical Preventive Services

Sec. 4101. School-based health centers.

Sec. 4102. Oral health care prevention activities.

Sec. 4103. Medicare coverage of annual dental services.

Sec. 4104. Removal of barriers to preventive services in Medicaid.

Sec. 4105. Evidence-based coverage of preventive services in Medicare.

Sec. 4106. Improving access to preventive services for eligible adults in Medicaid.

Sec. 4107. Coverage of comprehensive tobacco cessation services for pregnant women in Medicaid.
Sec. 4108. Incentives for prevention of chronic diseases in Medicaid.

Subtitle C—Creating Healthier Communities
Sec. 4201. Community transformation grants.
Sec. 4202. Healthy aging, living well; evaluation of community-based prevention and wellness programs for Medicare beneficiaries.
Sec. 4203. Removing barriers and improving access to wellness for individuals with disabilities.
Sec. 4204. Immunizations.
Sec. 4205. Nutrition labeling of standard menu items at chain restaurants.
Sec. 4206. Demonstration project concerning individualized wellness plan.
Sec. 4207. Reasonable break time for nursing mothers.

Subtitle D—Support for Prevention and Public Health Innovation
Sec. 4301. Research on optimizing the delivery of public health services.
Sec. 4302. Understanding health disparities: data collection and analysis.
Sec. 4303. CDC and employer-based wellness programs.
Sec. 4304. Epidemiology—Laboratory Capacity Grants.
Sec. 4305. Advancing research and treatment for pain care management.
Sec. 4306. Funding for Childhood Obesity Demonstration Project.

Subtitle E—Miscellaneous Provisions
Sec. 4401. Sense of the Senate concerning CBO scoring.
Sec. 4402. Effectiveness of Federal health and wellness initiatives.

Subtitle B—Innovations in the Health Care Workforce
Sec. 4501. Financial assistance for training for diversity.
Sec. 4502. Medicare Federally qualified health center improvements.
Sec. 4503. Health center quality improvement projects.
Sec. 4504. National demonstration projects in农村 communities.

Title V—Health Care Workforce
Subtitle A—Purpose and Definitions
Sec. 5001. Purpose.
Sec. 5002. Definitions.

Subtitle B—Innovations in the Health Care Workforce
Sec. 5101. National health care workforce commission.
Sec. 5102. State health care workforce development grants.

Subtitle C—Increasing the Supply of the Health Care Workforce
Sec. 5201. Federally supported student loan funds.
Sec. 5202. Nursing student loan program.
Sec. 5203. Health care workforce loan repayment programs.
Sec. 5204. Public health workforce recruitment and retention programs.
Sec. 5205. Advanced health workforce recruitment and retention programs.
Sec. 5206. Grants for State and local programs.
Sec. 5207. Funding for National Health Service Corps.
Sec. 5208. Nurse-managed health clinics.
Sec. 5209. Elimination of cap on commissioned corps.
Sec. 5210. Establishing a Ready Reserve Corps.

Subtitle D—Enhancing Health Care Workforce Education and Training
Sec. 5301. Training in family medicine, general internal medicine, general pediatrics, and physician assistantship.
Sec. 5302. Training opportunities for direct care workers.
Sec. 5303. Training in general, pediatric, and public health dentistry.
Sec. 5304. Alternative dental health care providers demonstration project.
Sec. 5305. Geriatric education and training; career awards; comprehensive geriatric education.
Sec. 5306. Mental and behavioral health education and training grants.
Sec. 5307. Cultural competency, prevention, and public health and individual imaging training.
Sec. 5308. Advanced nursing education grants.
Sec. 5309. Nurse education, practice, and retention grants.
Sec. 5310. Loan repayment and scholarship program.
Sec. 5311. Nurse faculty loan program.
Sec. 5312. Authorization of appropriations for parts B through D of title VIII.
Sec. 5313. Grants to promote the community health workforce.
Sec. 5314. Fellowship training in public health.
Sec. 5315. United States Public Health Sciences Track.

Subtitle E—Supporting the Existing Health Care Workforce
Sec. 5401. Centers of excellence.
Sec. 5402. Health care professionals training for diversity.
Sec. 5403. Interdisciplinary, community-based training.
Sec. 5404. Workforce diversity grants.
Sec. 5405. Primary care extension program.
Sec. 5410. Community health service loans.
Sec. 5411. Expanding access to primary care services and general surgery services.
Sec. 5412. Medicare Federally qualified health center improvements.
Sec. 5413. Distribution of additional residency positions.
Sec. 5414. Counting resident time in outpatient settings and allowing flexibility for jointly operated residency training programs.
Sec. 5415. Rules for counting resident time for didactic and scholarly activities and other activities.
Sec. 5416. Preservation of resident cap positions from closed hospitals.
Sec. 5417. Demonstration projects to address health professions workforce needs; extension of family-to-family health information centers.
Sec. 5418. Increasing teaching capacity.
Sec. 5419. Graduate nurse education demonstrations.

Subtitle G—Improving Access to Health Care Services
Sec. 5601. Spending for Federally Qualified Health Centers (FQHCs).
Sec. 5602. Negotiated rate setting for development of methodology and criteria for designating medically underserved populations and health professions shortage areas.
Sec. 5603. Reauthorization of the Wakefield Emergency Medical Services for Children Program.
Sec. 5604. Co-locating primary and specialty care in community-based mental health settings.
Sec. 5605. Key National indicators.

Subtitle H—General Provisions
Sec. 5701. Reports.

Title VI—Transparency and Program Integrity
Subtitle A—Physician Ownership and Other Participation Requirements
Sec. 6001. Limitation on Medicare exception to the prohibition on certain physician referrals for hospitals.
Sec. 6002. Transparency reports and reporting of physician ownership or investment interests.
Sec. 6003. Disclosure requirements for in-office ancillary services exception to the prohibition on physician self-referral for certain services with disabilities.
Sec. 6004. Prescription drug sample transparency.
Sec. 6005. Pharmacy benefit managers transparency requirements.

Subtitle B—Nursing Home Transparency and Improvement
Part I—Improving Transparency of Information
Sec. 6101. Required disclosure of ownership and additional disclosures.
Sec. 6102. Accountability requirements for skilled nursing facilities and nursing facilities.
Sec. 6103. Nursing home compare Medicare website.
Sec. 6104. Reporting of expenditures.
Sec. 6105. Standardized complaint form.
Sec. 6106. Ensuring staffing accountability.
Sec. 6107. GAO study and report on Five-Star Quality Rating System.

Part II—Targeting Enforcement
Sec. 6111. Civil money penalties.
Sec. 6112. National independent monitor demonstration project.
Sec. 6113. Notification of facility closure.
Sec. 6114. National demonstration projects on culture change and use of information technology in nursing homes.

Part III—Improving Staff Training
Sec. 6121. Dementia and abuse prevention training.

Subtitle C—Nationale Program for National and State Background Checks on Direct Patient Access Employees of Long-Term Care Facilities and Providers
Sec. 6201. Nationwide program for National and State background checks on direct patient access employees of long-term care facilities and providers.

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

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

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

Subtitle F—Additional Medicaid Program Integrity Provisions

Sec. 6501. Prohibition on payments to institutions or entities located outside of the United States.

Sec. 6502. Overpayments.

Sec. 6503. Mandatory State use of national correct coding initiative.

Sec. 6504. General effective date.

Sec. 6505. Requirement to report expanded set of data elements under MMIS to detect fraud and abuse.

Sec. 6506. Prohibition on payments to institutions or entities located outside of the United States.

Sec. 6507. Mandatory State use of national correct coding initiative.

Sec. 6508. General effective date.

Sec. 6509. Development of model uniform report form.

Sec. 6510. Application of State law to combat fraud and abuse.

Sec. 6511. Enabling the Department of Labor to issue administrative summary cease and desist and temporary cease and desist orders against plans that are financially hazardous condition.

Sec. 6512. MSWA plan reporting with Department of Labor.

Sec. 6513. Permitting evidentiary privilege and confidential communications.

Subtitle G—Additional Program Integrity Provisions

Sec. 6601. Prohibition on false statements and representations.

Sec. 6602. Clarifying definition.

Sec. 6603. Development of model uniform report form.

Sec. 6604. Applicability of State law to combat fraud and abuse.

Sec. 6605. Enabling the Department of Labor to issue administrative summary cease and desist and temporary cease and desist orders against plans that are financially hazardous condition.

Sec. 6606. MSWA plan reporting with Department of Labor.

Sec. 6607. Billing agents, clearinghouses, or other alternate payees required to register under Medicaid.

Sec. 6608. Requirement to expand set of data elements under MMIS to detect fraud and abuse.

Sec. 6609. Prohibition on payments to institutions or entities located outside of the United States.

Sec. 6610. Overpayments.

Sec. 6611. Mandatory State use of national correct coding initiative.

Sec. 6612. General effective date.

Sec. 6613. Prohibition on false statements and representations.

Sec. 6614. Clarifying definition.

Sec. 6615. Development of model uniform report form.

Sec. 6616. Applicability of State law to combat fraud and abuse.

Sec. 6617. Enabling the Department of Labor to issue administrative summary cease and desist and temporary cease and desist orders against plans that are financially hazardous condition.

Sec. 6618. MSWA plan reporting with Department of Labor.

Sec. 6619. Permitting evidentiary privilege and confidential communications.

Sec. 6701. Short title of subtitle.

Sec. 6702. Definitions.

Sec. 6703. Administration.

Subtitle I—Sense of the Senate Regarding Medical Malpractice

Sec. 6801. Sense of the Senate regarding medical malpractice.

TITLE I—QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS

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

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

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

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

"PART A—INDIVIDUAL AND GROUP MARKET REFORMS;"

(b) by redesigning sections 2704 through 2707 as sections 2725 through 2728, respectively;

(c) by redesigning sections 2711 through 2713 as sections 2731 through 2733, respectively;

(d) by redesigning sections 2721 through 2723 as sections 2733 through 2737, respectively; and

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

"Subpart II—Improving Coverage"

SEC. 2711. NO LIFETIME OR ANNUAL LIMITS.

(a) In General.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not rescind such plan or coverage with respect to an enrollee once the enrollee is covered under such plan or coverage involved, except that this section shall not apply to a covered individual who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage. Such plan or coverage may not be cancelled except with prior notice to the enrollee, and only as permitted under section 2722(b)."
definition of ‘dependent’ as used in the Internal Revenue Code of 1986 with respect to the tax treatment of the cost of coverage.

SEC. 2715. DEVELOPMENT AND UTILIZATION OF STANDARDIZED DEFINITIONS OF COVERAGE DOCUMENTS AND STANDARDIZED DEFINITIONS.

(a) In general.—Not later than 12 months after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary shall develop standards for use by a group health plan and a health insurance issuer offering group or individual health insurance coverage, in compiling and providing to enrollees a summary of benefits and coverage explanation that accurately describes the benefits and coverage under the applicable plan or coverage. In developing such standards, the Secretary shall consult with the National Association of Insurance Commissioners (referred to in this section as the ‘NAIC’), a working group composed of representatives of health insurance and consumer advocacy organizations, health insurance issuers, health care professionals, patient advocates including those representing individuals with limited English proficiency, and other qualified individuals.

(b) REQUIREMENTS.—The standards for the summary of benefits and coverage explanation developed under subsection (a) shall provide for the following:

(1) APPEARANCE.—The standards shall ensure that the summary of benefits and coverage is presented in a uniform format that does not exceed 4 pages in length and does not include print smaller than 12-point font.

(2) LANGUAGE.—The standards shall ensure that the summary is presented in a culturally and linguistically appropriate manner and utilizes terminology understandable by the average plan enrollee.

(3) CONTENTS.—The standards shall ensure that the summary of benefits and coverage includes:

(A) uniform definitions of standard insurance terms and medical terms (consistent with subsection (g)) so that consumers may compare health insurance coverage and understand the terms of coverage (or exception to such coverage);

(B) a description of the coverage, including cost-sharing for:

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

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

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

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

(E) the renewability and continuation of coverage provisions;

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

(G) a statement of whether the plan or coverage:

(i) provides minimum essential coverage (as defined under section 5000A(a)(1) of the Internal Revenue Code 1986); and

(ii) includes a method to determine the plan or coverage share of the total allowed costs of benefits provided under the plan or coverage is not less than 60 percent of such costs;

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

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

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

(d) REQUIREMENT TO PROVIDE.—

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

(A) an applicant at the time of application;

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

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

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

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

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

(B) an entity described in paragraph (2) of subsection (a) of the self-insured group health plan, the plan sponsor or designated administrator of the plan (as such terms are defined in section 3(16) of the Employee Retirement Income Security Act of 1974).

(4) NOTICE OF MODIFICATIONS.—If a group health plan or health insurance issuer makes any material modification in any of the terms or conditions of the plan or coverage, the plan or issuer shall provide notice of such modification to enrollees not later than 60 days prior to the date on which such modification will become effective.

(e) PREEMPTION.—The standards developed under subsection (a) shall preempt any other comparable requirement of State law.

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

(g) DEVELOPMENT OF STANDARD DEFINITIONS.—

(1) IN GENERAL.—The Secretary shall, by regulation, provide for the development of standards for the definitions of terms used in health insurance coverage, including the insurance-related terms described in paragraph (2) and the medical terms described in paragraph (3).

(2) INSURANCE-RELATED TERMS.—The insurance-related terms described in this paragraph are premium, deductible, co-insurance, co-payment, out-of-pocket limit, preferred provider, non-preferred provider, out-of-network provider, coinsurance, deductible, and the total of the amounts payable (other than customary and reasonable fees), excluded services, grieve and appeals, and such other terms as the Secretary determines are important to define the terms of a health insurance coverage and understand the terms of their coverage.

(3) MEDICAL TERMS.—The medical terms described in this paragraph are hospitalization, urgent care, emergency care, emergency room care, physician services, prescription drugs, durable medical equipment, home health care, skilled nursing care, rehabilitation services, hospice services, emergency medical transportation, and such other terms as the Secretary determines are important to define the medical benefits offered by health insurance and understand the extent to which these medical benefits (or exceptions to those benefits).

SEC. 2716. PROHIBITION OF DISCRIMINATION BASED ON SALARY.

(a) IN GENERAL.—A group health plan (other than a self-insured plan) may not establish rules relating to the health insurance coverage eligibility (including continued eligibility) of any full-time employee under the terms of the plan that are based on the total hourly or annual salary of the employee or otherwise establish eligibility rules that have the effect of discriminating in favor of higher wage employees.

(b) LIMITATIONS.—Subsection (a) shall not be construed to preclude a plan from establishing contribution requirements for enrollment in the plan or coverage that provide for the payment by employees with lower hourly or annual compensation of a lower dollar or percentage contribution than the payment required of similarly situated employees with a higher hourly or annual compensation.

SEC. 2717. ENSURING THE QUALITY OF CARE.

(a) QUALITY REPORTING.—

(1) IN GENERAL.—Not later than 2 years after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary, in consultation with experts in health care quality and stakeholders, shall develop standards for the reporting requirements by a group health plan, and a health insurance issuer offering group or individual health insurance coverage, with respect to plan or coverage benefits and health care provider reimbursement structures that—

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

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

(C) implement activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage; and

(D) implement wellness and health promotion activities.

(2) REPORTING REQUIREMENTS.—

(A) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall annually submit to the Secretary, and to enrollees pursuant to the standards under the plan or coverage, a report on whether the benefits under the plan or coverage satisfy the elements described in subparagraphs (A) through (D) of paragraph (1).

(B) TIMING OF REPORTS.—A report under subparagraph (A) shall be made available to
an enrollee under the plan or coverage during each open enrollment period.

"(C) AVAILABILITY OF REPORTS.—The Secretary shall make reports submitted under subsection (a)(3) available to the public through an Internet website.

"(D) PENALTIES.—In developing the reporting requirements under paragraph (1), the Secretary shall make reports received under this section available to the public on an Internet website, or otherwise, and impose appropriate penalties for non-compliance with such requirements.

"(E) EXCEPTIONS.—In developing the reporting requirements under paragraph (1), the Secretary may provide for exceptions to such requirements for group health plans and health insurance issuers that substantially and prospectively reduce the likelihood of non-compliance or eliminate the need for such reports.

"(b) WELLNESS AND PREVENTION PROGRAMS.—For purposes of subsection (a)(1)(D), wellness and health promotion activities may include personal wellness and prevention services, which are coordinated, maintained or delivered by a health care provider, a wellness and prevention plan manager, or a health, wellness or prevention services organization that conducts health risk assessments or offers ongoing face-to-face, telephonic or web-based intervention efforts to improve the health of participants, and which may include the following wellness and prevention efforts:

"(1) Smoking cessation.
"(2) Weight management.
"(3) Stress management.
"(4) Physical fitness.
"(5) Nutrition.
"(6) Heart disease prevention.
"(7) Healthy lifestyle support.
"(8) Diabetes prevention.
"(9) Preventing or reducing the number of lost workdays or lost work hours related to chronic disease.

"(c) STUDY AND REPORT.—Not later than 180 days after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary shall promulgate regulations that provide criteria for determining whether a reimbursement structure is described in subsection (a).

"(d) STUDY AND REPORT.—Not later than 2 years after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary shall promulgate regulations that provide criteria for determining whether reimbursement structure is described in subsection (a).

"(e) REGULATIONS.—Not later than 2 years after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary shall promulgate regulations that provide criteria for determining whether reimbursement structure is described in subsection (a).

"(f) DEFINITIONS.—The Secretary, in consultation with the National Association of Insurance Commissioners, shall establish uniform definitions for the activities reported under this section.

"SEC. 2719. APPEALS PROCESS.

"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:

"(1) have in effect an internal claims appeal process;
"(2) provide notice to enrollees, in a culturally and linguistically appropriate manner, of available internal and external appeal processes, and the availability of any applicable office of health insurance consumer assistance or health insurance ombudsman program shall be required to collect and report data to the Secretary on the types of problems and inquiries encountered under subsection (a).

"SEC. 1002. HEALTH INSURANCE CONSUMER INFORMATION.

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

"SEC. 2793. HEALTH INSURANCE CONSUMER INFORMATION.

"(a) IN GENERAL.—The Secretary shall—

"(1) establish, expand, or provide support for—

"(1) offices of health insurance consumer assistance;
"(2) health insurance ombudsman programs.
justifications for all health insurance issuers. 

(b) CONTINUING PREMIUM REVIEW PROCESSES. 

(1) INFORMING SECRETARY OF PREMIUM INCREASE PATTERNS.—As a condition of receiving a grant under subsection (c)(1), a State, through its Commissioner of Insurance, shall—

(A) provide the Secretary with information about trends in premium increases in health insurance coverage in premium rating areas of the State;

(B) make recommendations, as appropriate, to the State Exchange about whether particular health insurance issuers should be excluded from participation in the Exchange based on a pattern or practice of excessive or unjustified premium increases.

(2) MONITORING BY SECRETARY OF PREMIUM INCREASES.—

(A) IN GENERAL.—Beginning with plan years beginning in 2014, the Secretary, in conjunction with the States and consistent with the provisions of subsection (a)(2), shall monitor premium increases of health insurance coverage offered through an Exchange and outside of an Exchange.

(B) COMMENTS IN OPENING EXCHANGE.—In determining under section 1312(f)(2)(B) of the Patient Protection and Affordable Care Act whether to offer qualified health plans through a public health insurance exchange established by the State under an exchange, the State shall take into account any excess of premium growth outside of the Exchange as compared to the rate of such growth inside the Exchange.

(c) GRANTS IN SUPPORT OF PROCESSES.—

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

(A) the development of an appropriate under State law, approving premium increases for health insurance coverage; and

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

(2) FUNDING.—

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

(B) FURTHER AVAILABILITY FOR INSURANCE REFORM AND CONSUMER PROTECTION.—If the amounts appropriated under subparagraph (A) are obligated under grants under paragraph (1) by the end of fiscal year 2014, any remaining funds shall remain available to the Secretary for grants to States for planning and implementing the insurance reforms and consumer protections under part A.

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

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

(ii) a State qualifying for a grant under paragraph (1) shall receive less than $1,000,000, or more than $5,000,000 for a grant year.

Sec. 1004. EFFECTIVE DATES 

(a) IN GENERAL.—Except as provided for in subsection (b), this subtitle (and the amendments made by this subtitle) shall become effective for plan years beginning on or after the date of enactment of this Act, except that the amendments made by sections 1002 and 1003 shall become effective for fiscal years beginning with fiscal year 2010. 

(b) SPECIAL RULE.—The amendments made by sections 1002 and 1003 shall take effect on the date of enactment of this Act during the 6 months after the date of enactment of this Act, during the 6 months after the date on which such individual is applying for coverage through the high risk pool; and

(c) PROTECTION AGAINST DUMPING RISK BY INSURERS.—

(1) IN GENERAL.—The Secretary shall establish criteria for determining whether health insurance issuers and employment-based health plans have discouraged an individual from remaining enrolled in prior coverage based on that individual’s health status.

(2) SANCTIONS.—An issuer or employment-based health plan shall be responsible for reimbursing the program under this section for the medical expenses incurred by the program for an individual whose covered through its Commissioner of Insurance, the State shall take into account any excess of premium growth outside of the Exchange as compared to the rate of such growth inside the Exchange.

(c) GRANTS IN SUPPORT OF PROCESSES.—

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

(A) the development of an appropriate under State law, approving premium increases for health insurance coverage; and

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

(2) FUNDING.—

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

(B) FURTHER AVAILABILITY FOR INSURANCE REFORM AND CONSUMER PROTECTION.—If the amounts appropriated under subparagraph (A) are obligated under grants under paragraph (1) by the end of fiscal year 2014, any remaining funds shall remain available to the Secretary for grants to States for planning and implementing the insurance reforms and consumer protections under part A.

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

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

(ii) a State qualifying for a grant under paragraph (1) shall receive less than $1,000,000, or more than $5,000,000 for a grant year.

Sec. 1004. EFFECTIVE DATES 

(a) IN GENERAL.—Except as provided for in subsection (b), this subtitle (and the amendments made by this subtitle) shall become effective for plan years beginning on or after the date of enactment of this Act, except that the amendments made by sections 1002 and 1003 shall become effective for fiscal years beginning with fiscal year 2010. 

(b) SPECIAL RULE.—The amendments made by sections 1002 and 1003 shall take effect on the date of enactment of this Act during the 6 months after the date of enactment of this Act, during the 6 months after the date on which such individual is applying for coverage through the high risk pool; and

(c) PROTECTION AGAINST DUMPING RISK BY INSURERS.—

(1) IN GENERAL.—The Secretary shall establish criteria for determining whether health insurance issuers and employment-based health plans have discouraged an individual from remaining enrolled in prior coverage based on that individual’s health status.

(2) SANCTIONS.—An issuer or employment-based health plan shall be responsible for reimbursing the program under this section for the medical expenses incurred by the program for an individual whose covered through its Commissioner of Insurance, the State shall take into account any excess of premium growth outside of the Exchange as compared to the rate of such growth inside the Exchange.

(c) GRANTS IN SUPPORT OF PROCESSES.—

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

(A) the development of an appropriate under State law, approving premium increases for health insurance coverage; and

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

(2) FUNDING.—

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

(B) FURTHER AVAILABILITY FOR INSURANCE REFORM AND CONSUMER PROTECTION.—If the amounts appropriated under subparagraph (A) are obligated under grants under paragraph (1) by the end of fiscal year 2014, any remaining funds shall remain available to the Secretary for grants to States for planning and implementing the insurance reforms and consumer protections under part A.

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

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

(ii) a State qualifying for a grant under paragraph (1) shall receive less than $1,000,000, or more than $5,000,000 for a grant year.
(A) In general.—Except as provided in subparagraph (B), coverage of eligible individuals under a high risk pool in a State shall terminate on January 1, 2014.

(b) Exchange.—The Secretary shall develop procedures to provide for the transition of eligible individuals enrolled in health insurance coverage offered through such pool at the termination of the early retiree is the spouse, surviving spouse, or dependent of such retiree. In determining the amount of a claim for purposes of this subsection, the participating employment-based plan shall take into account any negotiated price concessions (such as discounts, direct or indirect subsidies, rebates, and price information) obtained by such plan with respect to such health benefit. For purposes of determining the amount of any such claim, the costs paid by the early retiree or the spouse, surviving spouse, or dependent of such retiree.

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

(3) Limit.—To be eligible for reimbursement under the program, a claim submitted by a participating employment-based plan shall not be less than $15,000 nor greater than $90,000. Such amounts shall be adjusted each fiscal year based on the percentage increase in the Medical Care Component of the Consumer Price Index for Urban Consumers (rounded to the nearest multiple of $1,000) for the year involved.

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

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

(6) Appeals.—The Secretary shall establish—

(A) an appeals process to permit participants or their beneficiaries to appeal a determination of the Secretary with respect to claims submitted under this section; and

(B) procedures to protect against fraud, waste, and abuse under paragraphs (1), (2), and (3).

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

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

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

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

(a) Internet Portal to Affordable Coverage Options.—

(1) Immediate Establishment.—Not later than July 1, 2010, the Secretary, in consultation with the States, shall establish a mechanism, including an Internet website, through which a resident of any State may identify affordable health insurance coverage options in that State.

(b) Connecting to Affordable Coverage.—An Internet website established under paragraph (1) shall, to the extent practicable, provide residents of any State with access to information from at least the following coverage options:

(1) Health insurance coverage offered by health insurance issuers, other than coverage under the Federal Employees Health Benefits program, available 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).

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

(3) Coverage under title XXI of the Social Security Act.

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

(5) Coverage under high risk pool under section 1101.

(c) Enhancing Comparative Purchasing Options.—

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

(2) Use of Form.—The Secretary shall use this form to include information concerning coverage options on the Internet website established under subsection (a).

SEC. 1104. ADMINISTRATIVE SIMPLIFICATION.

(a) Purpose of Administrative Simplification.—Section 261 of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320c-1 note) is amended—

(1) by inserting “uniform” before “standards”; and

(2) by inserting “and to reduce the clerical burden on patients, health care providers, and health plans” before the period at the end.
(b) OPERATING RULES FOR HEALTH INFORMATION TRANSACTIONS.—

(1) DEFINITION OF OPERATING RULES.—Section 1171 of the Social Security Act (42 U.S.C. 1320d–2) is amended by adding at the end the following:

"(9) OPERATING RULES.—The term ‘operating rules’ means the necessary business rules that are necessary to enable the accurate and reliable exchange of information that are not defined by a standard or its implementation specifications as adopted for purposes of this part.

(2) TRANSACTION STANDARDS; OPERATING RULES AND COMPLIANCE.—Section 1173 of the Social Security Act (42 U.S.C. 1320d–4) is amended—

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

"(J) OPERATING RULES FOR ADMINISTRATIVE TRANSACTIONS.—

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

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

"(B) OPERATING RULES FOR HEALTH INFORMATON TECHNOLOGY.—The standards and associated operating rules adopted by the Secretary shall—

"(1) define the necessary business rules affecting health care stakeholders and are consistent with and do not conflict with other existing standards;

"(2) represent a consensus view of the health care stakeholders and are consistent with and do not conflict with other existing standards;

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

"(h) COMPLIANCE.—

"(A) ELIGIBILITY FOR A HEALTH PLAN, HEALTH CLAIM STATUS, ELECTRONIC FUNDS TRANSFERS, HEALTH CARE PAYMENT AND REMITTANCE ADVICE.—Not later than December 31, 2013,

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

"(A) IN GENERAL.—A health plan including entities described under paragraph (3) shall file a statement with the Secretary, in such form as the Secretary may require, certifying that the data and information systems for such plan are in compliance with any applicable standards and associated operating rules (as described under paragraph (7) of section 1171) and associated operating rules (as described under paragraph (9) of such section) for electronic funds transfers, eligibility for a health plan, health claim status, and health care payment and remittance advice, respectively.

"(B) HEALTH CLAIMS OR EQUIVALENT ENCOUNTER INFORMATION, ENROLLMENT AND DESENNROLLMENT IN A HEALTH PLAN, HEALTH PLAN PREMIUM PAYMENTS, HEALTH CLAIMS ATTACHMENTS, REFERRAL CERTIFICATION AND AUTHORIZATION.—Not later than December 31, 2015, a health plan shall file a statement with the Secretary, in such form as the Secretary may require, certifying that the data and information systems for such plan are in compliance with any applicable standards and associated operating rules (as described under paragraph (1) of such section) for electronic funds transfers, eligibility for a health plan, health claim status, and health care payment and remittance advice, respectively.
"(ii) establishes a standard (as described under subsection (a)(1)(B)) or associated operating rules (as described under subsection (i)(5)) for any other financial and administrative transactions.

(B) DATE OF COMPLIANCE.—A health plan shall comply with such requirements not later than the effective date of the applicable standard or operating rule.

(6) AUDITS OF HEALTH PLANS.—The Secretary shall conduct periodic audits to ensure that health plans (including entities described under paragraph (4)(B)) are in compliance with such standards and operating rules that are described under paragraph (1) or subsection (a)(1)(B).

(7) REVIEW AND AMENDMENT OF STANDARDS AND OPERATING RULES.—

(A) ESTABLISHMENT.—Not later than January 1, 2014, the Secretary shall establish a review committee (as described under paragraph (4)).

(B) EVALUATIONS AND REPORTS.—

(i) HEARINGS.—Not later than April 1, 2014, and not less than biennially thereafter, the Secretary, acting through the review committee, shall conduct hearings to evaluate the standards and associated operating rules established under this section.

(ii) REPORT.—Not later than July 1, 2014, and not less than biennially thereafter, the Secretary shall provide the review committee with an evaluation of the standards and operating rules established under this section, including a recommendation to amend such standards or operating rules.

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

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

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

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

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

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

(G) PAYMENT DUE DATE.—Payment by a health plan for a penalty fee imposed under this section shall be due not later than January 1, 2014. For purposes of this section, the term ‘Secretary’ means the Secretary of the Treasury (as described in section 1173(a)(2)(B) of the Social Security Act).

(7) EXPANSION OF ELECTRONIC TRANSACTIONS IN MEDICARE.—Section 1862(a) of the Social Security Act (as described in section 1395y(a) of the Internal Revenue Code) is amended—

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

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

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

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

SEC. 1105. EFFECTIVE DATE.

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

S11617

November 19, 2009

CONGRESSIONAL RECORD — SENATE
SEC. 2701. FAIR HEALTH INSURANCE PREMIUMS.

(a) PROHIBITING DISCRIMINATORY PREMIUM RATES.—

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

SEC. 2702. GUARANTEED RENEWABILITY OF COVERAGE.

SEC. 2703. GUARANTEED RENEWABILITY OF COVERAGE.

SEC. 2703. PROHIBITING DISCRIMINATION AGAINST INDIVIDUAL PARTICIPANTS AND BENEFICIARIES BASED ON HEALTH STATUS.

SEC. 2704. PROHIBITION OF PREEXISTING CONDITION EXCLUSION.

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

SEC. 2706. CRITICAL-ILLNESS INSURANCE.

SEC. 2707. SPECIAL RULE FOR LARGE GROUP MARKET.

SEC. 2708. FAIR ACCESS TO HEALTH INSURANCE.

SEC. 2709. GUARANTEE OF ANNUITY CONTRACTS.
as spouses or spouses and dependent children) may participate fully in the wellness program, such reward shall not exceed 30 percent of the cost of the coverage in which an individual or dependent is enrolled. For purposes of this paragraph, the cost of coverage shall be determined based on the total amount of employee and family contributions to the benefit package under which the employee is (or the employee and any dependents are) receiving coverage. A reward may be in the form of a discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism (such as deductibles, copayments, or coinsurance), the allocation or the value of a benefit that would otherwise not be provided under the plan. The Secretaries of Labor, Health and Human Services, and the Treasury may increase the reward available under this subparagraph to up to 50 percent of the cost of coverage if the Secretaries determine that such an increase is appropriate.

	(2) The wellness program shall be reasonably designed to promote health or prevent disease. A program complies with the preceding sentence if the program has a reasonable potential of changing behavior; and

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

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

	(3) REQUIREMENTS.—

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

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

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

	(B) THE PLAN OR ISSUER INVOLVED SHALL DISCLOSE—

	(i) for a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard; and

	(ii) for a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is medically inadvisable to attempt to satisfy the otherwise applicable standard.

	(C) THE PLAN OR ISSUER INVOLVED SHALL DISCLOSE—

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

	(E) THE PLAN OR ISSUER INVOLVED SHALL DISCLOSE—

	(i) for an alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard; and

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

	(F) THE PLAN OR ISSUER INVOLVED SHALL DISCLOSE—

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

	(2) EXPANSION OF DEMONSTRATION PROJECT.—

	(a) IN GENERAL.—Not later than July 1, 2014, the Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, shall establish a 10-State demonstration project. States shall apply the provisions of subsection (i) to programs of health promotion offered by a health insurance issuer that offers health insurance coverage in the individual market in such State.

	(b) REQUIREMENTS.—

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

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

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

	(B) THE PLAN OR ISSUER INVOLVED SHALL DISCLOSE—

	(i) for a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard; and

	(ii) for a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is medically inadvisable to attempt to satisfy the otherwise applicable standard.

	(C) THE PLAN OR ISSUER INVOLVED SHALL DISCLOSE—

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

	(E) THE PLAN OR ISSUER INVOLVED SHALL DISCLOSE—

	(i) for an alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard; and

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

	(F) THE PLAN OR ISSUER INVOLVED SHALL DISCLOSE—

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

	(3) REPORTS.—

	(A) THE EFFECTIVENESS OF WELLNESS PROGRAMS.—

	(i) IN GENERAL.—Not later than 3 years after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, shall submit a report to the appropriate committees of Congress concerning—

	(A) the effectiveness of wellness programs (as defined in subsection (j)) in promoting health and preventing disease;

	(B) the impact of such wellness programs on the availability and affordability of coverage for participants and non-participants of such programs;

	(C) the impact of premium-based and cost-sharing incentives on participant behavior and the role of such programs in changing behavior; and

	(D) the effectiveness of different types of rewards.

	(B) DATA COLLECTION.—In preparing the report described in paragraph (1), the Secretary shall gather such information from employers who provide employees with access to wellness programs, including State and Federal agencies.

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

	SEC. 2706. NON-DISCRIMINATION IN HEALTH CARE.

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

	(b) INDIVIDUALS.—The provisions of section 1558 of the Patient Protection and Affordable Care Act (relating to non-discrimination) shall apply to a group health plan or health insurance issuer offering group or individual health insurance coverage.

	SEC. 2707. COMPREHENSIVE HEALTH INSURANCE COVERAGE.

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

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

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

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

	SEC. 2708. PROHIBITION ON EXCESSIVE WAITING PERIODS.

	A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not apply any waiting period (as defined in section 1558) that exceeds 90 days.

	PART II—OTHER PROVISIONS

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

(a) NO CHANGES TO EXISTING COVERAGE.—

	(1) IN GENERAL.—Nothing in this Act (or an amendment made by this Act) shall be construed to require that an individual terminate coverage under a group health plan or health insurance coverage in which such individual was enrolled on the date of enactment of this Act.
(2) CONTINUATION OF COVERAGE.—With respect to a group health plan or health insurance coverage in which an individual was enrolled on the date of enactment of this Act, this subtitle and subtitle A (and the amendments made by such subtitles) shall not apply to such plan or coverage, regardless of whether the individual renews such coverage after such date of enactment.

(b) ALLOWANCE FOR FAMILY MEMBERS TO JOIN CURRENT COVERAGE.—With respect to a group health plan or health insurance coverage in which an individual was enrolled at the date of enactment of this Act and which is renewed after such date, family members of such individual shall be permitted to enroll in such plan or coverage if such enrollment is permitted under the terms of the plan in effect as of such date of enactment.

(c) ALLOWANCE FOR NEW EMPLOYEES TO JOIN CURRENT PLAN.—A group health plan that provides coverage on the date of enactment of this Act may provide for the enrollment of new employees (and their families) in such plan, and this subtitle and subtitle A (and the amendments made by such subtitles) shall not apply with respect to such plan and such new employees (and their families).

(d) EFFECT ON COLLECTIVE BARGAINING AGREEMENTS.—In the case of health insurance coverage maintained pursuant to a collective bargaining agreement, or more collective bargaining agreements between employee representatives and one or more employers that was ratified before the date of enactment of this Act, the amendments of this subtitle and subtitle A (and the amendments made by such subtitles) shall not apply until the date on which the last of the collective bargaining agreements relating to the coverage terminates. Any coverage amendment made pursuant to a collective bargaining agreement relating to the coverage may conform to any requirement added by this subtitle or subtitle A (amendments) that is not the same as the requirement made by such collective bargaining agreement.

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

SEC. 1253. RATING REFORMS MUST APPLY UNIFORMLY TO ALL HEALTH INSURANCE ISSUERS AND GROUP HEALTH PLANS.

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

SEC. 1253. EFFECTIVE DATES.

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

Subtitle D—Available Coverage Choices for All Americans

PART I—ESTABLISHMENT OF QUALIFIED HEALTH PLANS

SEC. 1301. QUALIFIED HEALTH PLAN DEFINED.

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

(1) In general.—The term “qualified health plan” means a health plan that—

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

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

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

(ii) agrees to charge the same premium rate for each qualified health plan of the issuer without regard to whether the plan is offered through an Exchange or whether the plan is offered directly by the issuer or through an agent; and

(iii) complies with the requirements specified by the Secretary with respect to any premium rate charged under section 1311(d) and such other requirements as an applicable Exchange may establish.

(2) INCLUSION OF CO-OP PLANS AND COMMUNITY HEALTH INSURANCE OPTION.—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 1321, or a State standard or requirement made under section 1322 or a community health insurance option under section 1323, unless specifically provided for otherwise.

(b) TERMS RELATING TO HEALTH PLANS.—In this title:

(A) HEALTH PLAN.—

(i) In general.—The term “health plan” means a health insurance coverage and a group health plan.

(ii) Exception for self-insured plans and merewa.—Except to the extent specifically provided by this title, the term “health plan” shall not include a group health plan or multiple employer welfare arrangement to the extent the plan or arrangement is not subject to the Employee Retirement Income Security Act of 1974.

(B) HEALTH INSURANCE COVERAGE AND ISSUERS.—The term “health insurance coverage” and “health insurance issuer” have the meanings given such terms by section 514 of the Employee Retirement Income Security Act of 1974.

(C) TAKE INTO ACCOUNT THE HEALTH CARE NEEDS OF THE POPULATION.—In defining the essential health benefits described in paragraphs (1)(A) through (1)(M); and in revising the benefits under paragraph (1), the Secretary shall take into account the health care needs of the population, including the needs of diverse segments of the population, including children, persons with disabilities, and other groups.

(d) ESSENTIAL HEALTH BENEFITS REQUIREMENTS.

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

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

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

(3) subject to paragraph (1), and in revising the benefits under paragraph (1) unless the plan provides that—

(i) the essential health benefits described in paragraph (1) are 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.

(f) PROVIDE THAT IF A PLAN DESCRIBED IN SECTION 1311(b)(2)(B)(ii) (RELATING TO STAND-ALONE DENTAL BENEFITS PLANS) IS OFFERED THROUGH AN EXCHANGE, THE COVERAGE PROVIDED THROUGH SUCH EXCHANGE SHALL NOT BE TREATED AS A QUALIFIED HEALTH PLAN SOLELY BECAUSE THE PLAN DOES NOT OFFER COVERAGE OF BENEFITS OTHER THAN THE ESSENTIAL HEALTH BENEFITS DESCRIBED IN SECTION 1311,b(1) AND SUCH OTHER REQUIREMENTS AS AN APPLICABLE EXCHANGE MAY ESTABLISH.
subsection.

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

(1) VOLUNTARY CHOICE OF COVERAGE OF ABORTION SERVICES.

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

(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 subparagraphs (C) and (D).
(B)(i) or (B)(ii) as part of its essential health benefits for any plan year; and
(ii) 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) A qualified employer that purchases 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.

(C) Prohibition on Federal funds for abortion services in community health insurance option.
(i) Determination by Secretary.—The Secretary may not determine, in accordance with subparagraph (A)(ii), that the community health insurance option established under this paragraph shall provide coverage of services described in subparagraph (B)(i) as part of benefits for the plan year unless the Secretary—
(A) assures compliance with the require-
ments of paragraph (2);
(B) assures, in accordance with applicable provisions of generally accepted accounting requirements, circulars on funds management, the Office of Management and Budget, and guidance on accounting of the Government Accountability Office, that Federal funds are used for such coverage; and
(C) notwithstanding section 1323(e)(1)(C) or any other provision of this title, takes all necessary steps to assure that the United States does not bear the insurance risk for a community health insurance option’s coverage of services described in subparagraph (B)(i).

(ii) State requirement.—If a State requires, in addition to the essential health benefits required under section 1323(b)(3)(A), coverage of services described in subparagraph (B)(ii) for enrollees of a community health insurance option offered in such State, the issuer of the plan shall—
(A) assure that no Federal funds are flowing through or from the community health insurance option, and no other Federal funds, pay or defray the cost of providing services described in subparagraph (B)(i); the United States shall not bear the insurance risk for a State’s required coverage of services described in subparagraph (B)(i); and
(B) may not estimate such a cost at less than $1 per enrollee, per month.

(3) No effect on Federal civil rights laws.—Nothing in this Act shall be construed to preempt or otherwise have any effect on Federal laws regarding the prohibi-
tion 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.

(4) 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 abort-
ion; and
(iii) discrimination on the basis of the will-
ingness or refusal to provide, pay for, cover, or refer for abortion or to provide or participate in training to provide abortion.

(B) No effect on Federal civil rights law.—Nothing in this subsection shall alter the rights and obligations of employers and employees under title VII of the Civil Rights Act of 1964.

(C) Application of emergency services laws.—Nothing in this Act shall be construed to relieve any health care provider from providing emergency services as required by State or Federal law, including section 1867 of the Social Security Act (popularly known as “EMTALA”).

SEC. 1304. RELATED DEFINITIONS.
(a) Definitions relating to markets.—In this title:

(1) Group market.—The term “group market” means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by an employer.

(2) Individual market.—The term “individual market” means the market for health insurance coverage offered to individuals than in connection with a group health plan.

(b) Large and small group markets.—The terms “large group market” and “small group market” mean the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a large employer (as defined in subsection (b)(1)) or by a small employer (as defined in subsection (b)(2)).

(c) Employers.—In this title:

(1) Large employer.—The term “large em-
ployer” means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 101 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.

(2) Small employer.—The term “small em-
ployer” means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who em-
ployed an average of at least 1 but not more
than 100 employees on business days during the preceding calendar year and who em-
ployed at least 1 employee on the first day of the plan year.

(d) State option to treat 50 employers as small.—In the case of plan years beginning before January 1, 2016, a State may elect to treat employers that employed as many as 50 em-
ployees for “101 employees” in paragraph (1) and by substituting “50 employees” for “101 employees” in paragraph (2).

(e) Rules for determining employer size.—For purposes of this subsection—

(1) Application of aggregate rule for employers.—All persons treated as a single employer under subsection (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as 1 employer.

(2) Employers not in existence in pre-
ceding calendar year.—In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small or large employer shall be based on the average number of employees that it is reasonably ex-
pected such employer will employ on busi-
ness days in the current calendar year.

(f) Extraterritorial employers.—Any reference in this subsection to an employer shall include a reference to any predecessor of such em-
ployer.

(2) Continuation of participation for grow-
ing small employers.—If

(i) a qualified employer that is a small em-
ployer makes enrollment in qualified health insurance available to its employees through an Ex-
change; and

(ii) the employer elects to maintain such enrollment through the Exchange; and

(iii) the employer is also enrolled in a State’s qualified health plan and 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, to bear the insurance risk for a community health insurance option’s coverage of services described in subparagraph (B)(i) or (B)(ii) as part of benefits for the plan year unless the Secretary—

(A) assures compliance with the require-
ments of paragraph (2);

(B) assures, in accordance with applicable provisions of generally accepted accounting requirements, circulars on funds management, the Office of Management and Budget, and guidance on accounting of the Government Accountability Office, that Federal funds are used for such coverage; and

(C) notwithstanding section 1323(e)(1)(C) or any other provision of this title, takes all necessary steps to assure that the United States does not bear the insurance risk for a community health insurance option’s coverage of services described in subparagraph (B)(i).

(ii) State requirement.—If a State requires, in addition to the essential health benefits required under section 1323(b)(3)(A), coverage of services described in subparagraph (B)(ii) for enrollees of a community health insurance option offered in such State, the issuer of the plan shall—

(A) assure that no Federal funds are flowing through or from the community health insurance option, and no other Federal funds, pay or defray the cost of providing services described in subparagraph (B)(i); the United States shall not bear the insurance risk for a State’s required coverage of services described in subparagraph (B)(i); and

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

(3) No effect on Federal civil rights laws.—Nothing in this Act shall be construed to preempt or otherwise have any effect on Federal laws regarding the prohibi-
tion 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.

(4) 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 abort-
ion; and

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

(B) No effect on Federal civil rights law.—Nothing in this subsection shall alter
(ii) the employer ceases to be a small employer by reason of an increase in the number of employees of such employer; the employer shall continue to be treated as a small employer for purposes of this subsection beginning with the increase and ending with the first day on which the employer does not make such enrollment available to its employees.

(c) RESPONSIBILITIES OF THE SECRETARY.—

(1) IN GENERAL.—The Secretary shall, by regulations established for the certification of health plans as qualified health plans. Such criteria shall require that, to be certified, a plan shall, at a minimum—

(A) meet all applicable requirements, and not employ marketing practices or benefit designs that have the effect of discouraging the enrollment in such plan by individuals with significant health needs;

(B) ensure a sufficient choice of providers (in a manner consistent with applicable network adequacy provisions under section 1302(b) of the Public Health Service Act), and provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers;

(C) include within health insurance plan networks those essential community providers, where available, that have predomi-

(na-low-income, medically-underserved individuals, such as health care providers de-

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

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

(i) receive such accreditation within a per-

iod established by an Exchange for such ac-

creditation that is applicable to all qualified health plans;

(E) implement a quality improvement strategy described in subsection (g)(1); and

(F) utilize a uniform enrollment form that qualified health plans may use (either electronically or on paper) in enrolling in qualified health plans offered through such Exchange, and that takes into account the criteria of the National Associa-

tion of Insurance Commissioners develops and submits to the Secretary;

(G) utilize the standard format established for presenting health benefits plan options; and

(H) provide information to enrollees and prospective enrollees, and to each Exchange in which it is offered, on any quality measures for health plan performance en-

dorsed under section 380B of the Public Health Service Act, as applicable.

(2) RULE OF CONSTRUCTION.—Nothing in paragraph (1)(C) shall be construed to require a qualified health plan to contract with a provider described in such paragraph if such provider recommends generally applicable payment rates of such plan.

(3) RATING SYSTEM.—The Secretary shall develop a rating system that would rate qualified health plans offered through an Exchange in each benefit level on the basis of the relative quality and price. The Exchange shall include the quality rating in the infor-

mation available to enrollees and providers through the Internet portal established under paragraph (4).

(4) INTERNET PORTALS.—The Secretary shall—

(A) continue to operate, maintain, and up-

date the Internet portal developed under sec-

tion 108(a) and to assist in develop-

ing and maintaining their own such portal; and

(B) make available for use by Exchanges a model template for an Internet portal that may be used to direct qualified individuals and qualified employers to qualified health plans, to assist such individuals and employ-

ees in determining whether they are eligible to participate in an Exchange or eligible for a premium tax credit or cost-sharing reduc-

tion and to present standardized informa-

tion (including quality ratings) regarding qualified health plans offered through an Ex-

change to assist consumers in making easy health plan choices.

Such template shall include, with respect to each qualified health plan offered through the Exchange in each rating area, the uniform outline of the plan and to a copy of the plan’s written policy.

(5) ENROLLMENT PERIODS.—The Secretary shall require an Exchange to provide for—

(A) an initial open enrollment, as deter-

mined by the Secretary (such determination to be made not later than 1 year after the enactment of this Act); and

(B) annual open enrollment periods, as de-

termined by the Secretary for calendar years after the initial enrollment period.

(6) SPECIAL ENROLLMENT PERIODS.—In section 9801 of the Internal Revenue Code of 1986 and other special enrollment periods under circumstances similar to such periods under part D of title XVIII of the Social Security Act; and

(D) special monthly enrollment periods for Indians (as defined in section 4 of the Indian Health Care Improvement Act).

(7) REQUIREMENTS.—

(1) IN GENERAL.—An Exchange shall be a governmental agency or nonprofit entity that is established by a State.

(2) OFFERING OF COVERAGE.—(A) IN GENERAL.—An Exchange shall make available any health plan that is not a qualified health plan.

(B) OFFERING OF STAND-ALONE DENTAL BENEFITS.—Each Exchange within a State shall allow any issuer of a plan that only provides limited scope dental benefits meeting the requirements of section 9832(c)(2)(A) of the Internal Revenue Code of 1986 to offer the plan through the Exchange (either separately or in conjunction with a qualified health plan) if the plan provides pediatric dental benefits meeting the requirements of section 1302(b)(1)(J).

(8) RULES RELATING TO ADDITIONAL REQUIRED BENEFITS.—(A) IN GENERAL.—Except as provided in subparagraph (B), an Exchange may make available a qualified health plan notwithstanding any provision of law that may re-

quire benefits other than the essential health benefits specified under section 1302(b).

(B) STATES MAY REQUIRE ADDITIONAL BENEFITS.—(I) IN GENERAL.—Subject to the require-

ments of clause (ii), a State may require that a qualified health plan offered in such State include benefits in addition to the essential health benefits specified under section 1302(b).

(ii) STATE MUST ASSUME COST.—A State shall make payments to or on behalf of an individual eligible for the premium tax credit under section 36B of the Internal Revenue
Code of 1986 and any cost-sharing reduction under section 1402 to defray the cost to the individual of any additional benefits described in clause (1) which are not eligible for such reduction under subsection (3)(b)(5) of such Code and section 1402(b)(4). (J) provide to each employer the name of each employee of the employer described in subparagraph (I)(i) who ceases coverage under a qualified health plan during a plan year (after the effective date of such cessation); and (K) establish the Navigator program described in subsection (i).

(b) PUBLISHING.—(A) NO FEDERAL FUNDS FOR CONTINUED OPERATIONS.—In establishing an Exchange under this section, the State shall ensure that such Exchange—

(i) is at least as large as a rating area described in section 2701(a) of the Public Health Service Act.

(ii) the Exchange determines that the plan meets the requirements of subparagraph (I)(ii) who ceases coverage under a qualified health plan during a plan year (after the effective date of such cessation); and (K) establish the Navigator program described in subsection (i).

(b) PUBLISHING.—(A) NO FEDERAL FUNDS FOR CONTINUED OPERATIONS.—In establishing an Exchange under this section, the State shall ensure that such Exchange—

(i) is at least as large as a rating area described in section 2701(a) of the Public Health Service Act.

(ii) the Exchange determines that the plan meets the requirements of subparagraph (I)(ii) who ceases coverage under a qualified health plan during a plan year (after the effective date of such cessation); and (K) establish the Navigator program described in subsection (i).

(b) PUBLISHING.—(A) NO FEDERAL FUNDS FOR CONTINUED OPERATIONS.—In establishing an Exchange under this section, the State shall ensure that such Exchange—

(i) is at least as large as a rating area described in section 2701(a) of the Public Health Service Act.

(ii) the Exchange determines that the plan meets the requirements of subparagraph (I)(ii) who ceases coverage under a qualified health plan during a plan year (after the effective date of such cessation); and (K) establish the Navigator program described in subsection (i).

(b) PUBLISHING.—(A) NO FEDERAL FUNDS FOR CONTINUED OPERATIONS.—In establishing an Exchange under this section, the State shall ensure that such Exchange—

(i) is at least as large as a rating area described in section 2701(a) of the Public Health Service Act.

(ii) the Exchange determines that the plan meets the requirements of subparagraph (I)(ii) who ceases coverage under a qualified health plan during a plan year (after the effective date of such cessation); and (K) establish the Navigator program described in subsection (i).

(b) PUBLISHING.—(A) NO FEDERAL FUNDS FOR CONTINUED OPERATIONS.—In establishing an Exchange under this section, the State shall ensure that such Exchange—

(i) is at least as large as a rating area described in section 2701(a) of the Public Health Service Act.

(ii) the Exchange determines that the plan meets the requirements of subparagraph (I)(ii) who ceases coverage under a qualified health plan during a plan year (after the effective date of such cessation); and (K) establish the Navigator program described in subsection (i).

(b) PUBLISHING.—(A) NO FEDERAL FUNDS FOR CONTINUED OPERATIONS.—In establishing an Exchange under this section, the State shall ensure that such Exchange—

(i) is at least as large as a rating area described in section 2701(a) of the Public Health Service Act.

(ii) the Exchange determines that the plan meets the requirements of subparagraph (I)(ii) who ceases coverage under a qualified health plan during a plan year (after the effective date of such cessation); and (K) establish the Navigator program described in subsection (i).

(b) PUBLISHING.—(A) NO FEDERAL FUNDS FOR CONTINUED OPERATIONS.—In establishing an Exchange under this section, the State shall ensure that such Exchange—

(i) is at least as large as a rating area described in section 2701(a) of the Public Health Service Act.

(ii) the Exchange determines that the plan meets the requirements of subparagraph (I)(ii) who ceases coverage under a qualified health plan during a plan year (after the effective date of such cessation); and (K) establish the Navigator program described in subsection (i).

(b) PUBLISHING.—(A) NO FEDERAL FUNDS FOR CONTINUED OPERATIONS.—In establishing an Exchange under this section, the State shall ensure that such Exchange—

(i) is at least as large as a rating area described in section 2701(a) of the Public Health Service Act.

(ii) the Exchange determines that the plan meets the requirements of subparagraph (I)(ii) who ceases coverage under a qualified health plan during a plan year (after the effective date of such cessation); and (K) establish the Navigator program described in subsection (i).

(b) PUBLISHING.—(A) NO FEDERAL FUNDS FOR CONTINUED OPERATIONS.—In establishing an Exchange under this section, the State shall ensure that such Exchange—

(i) is at least as large as a rating area described in section 2701(a) of the Public Health Service Act.

(ii) the Exchange determines that the plan meets the requirements of subparagraph (I)(ii) who ceases coverage under a qualified health plan during a plan year (after the effective date of such cessation); and (K) establish the Navigator program described in subsection (i).

(b) PUBLISHING.—(A) NO FEDERAL FUNDS FOR CONTINUED OPERATIONS.—In establishing an Exchange under this section, the State shall ensure that such Exchange—

(i) is at least as large as a rating area described in section 2701(a) of the Public Health Service Act.

(ii) the Exchange determines that the plan meets the requirements of subparagraph (I)(ii) who ceases coverage under a qualified health plan during a plan year (after the effective date of such cessation); and (K) establish the Navigator program described in subsection (i).

(b) PUBLISHING.—(A) NO FEDERAL FUNDS FOR CONTINUED OPERATIONS.—In establishing an Exchange under this section, the State shall ensure that such Exchange—

(i) is at least as large as a rating area described in section 2701(a) of the Public Health Service Act.

(ii) the Exchange determines that the plan meets the requirements of subparagraph (I)(ii) who ceases coverage under a qualified health plan during a plan year (after the effective date of such cessation); and (K) establish the Navigator program described in subsection (i).

(b) PUBLISHING.—(A) NO FEDERAL FUNDS FOR CONTINUED OPERATIONS.—In establishing an Exchange under this section, the State shall ensure that such Exchange—

(i) is at least as large as a rating area described in section 2701(a) of the Public Health Service Act.

(ii) the Exchange determines that the plan meets the requirements of subparagraph (I)(ii) who ceases coverage under a qualified health plan during a plan year (after the effective date of such cessation); and (K) establish the Navigator program described in subsection (i).
(A) a hospital with greater than 50 beds only if such hospital—
   (i) utilizes a patient safety evaluation system as described in part C of title IX of the Public Health Service Act and
   (ii) implements a mechanism to ensure that each patient receives a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post-discharge reinforcement by an appropriate health care professional; or

(B) any provider (except as provided only if such pro-

(2) EXCEPTIONS.—The Secretary may establish

reasonable exceptions to the require-

ments described in paragraph (1).

(3) The Secretary may by regulation adjust the number of beds de-

scribed in paragraph (1)(A).

(1) NAVIGATORS.—An Exchange shall estab-

lish a program under which it awards grants to entities described in paragraph (2) to carry out the duties described in paragraph (3).

(2) ELIGIBILITY.—

(A) IN GENERAL.—To be eligible to receive a grant under this paragraph, an entity shall demonstrate to the Exchange involved that the entity has existing relationships, or could readily establish relationships, with employees, employee-owners, and eligible consumers (including uninsured and underinsured con-

sumers), or self-employed individuals likely to be qualified to enroll in a qualified health plan.

(B) TYPES.—Entities described in subparagraph (A) may include trade, industry, and professional associations, commercial fish-

ing organizations, community and con-

sumer-focused nonprofit groups, chambers of commerce, unions, small business development centers, other licensed insurance agents and brokers, and other entities that—

(i) are capable of carrying out the duties described in paragraph (3); and

(ii) provide information consistent with the standards described under paragraph (5).

(3) DUTIES.—An entity that serves as a navig-

ator under a grant under this subsection shall—

(a) conduct public education activities to raise awareness of the availability of qualified health plans;

(b) distribute fair and impartial informa-

tion on all qualified health plans described for enrollment under paragraph (4);

(c) facilitate enrollment in qualified health plans;

(d) provide referrals to any applicable office of a Member of Congress, whether full-time or part-time employees employed by the offi-

cial office of a Member of Congress, whether in Washington, DC or outside of Washington, DC.

(4) NO PENALTY FOR TRANSFERRING TO MINI-

MUM ESSENTIAL COVERAGE OUTSIDE EX-

CHANGE.—An Exchange, or a qualified health plan offered through such Exchange, shall not impose any penalty or other fee on an indi-

vidual who cancels enrollment in a plan be-

cause the individual becomes eligible for mini-

mum essential coverage (as defined in section 5000A(f) of the Internal Revenue Code of 1986 without regard to paragraph (1)(C) or (D) thereof) or such coverage becomes afford-

able (within the meaning of section 36B(c)(2)(C) of such Code).

(5) EMPLOYER—

(a) CHOICE.—

(1) QUALIFIED INDIVIDUALS.—A qualified in-

dividual may enroll in any qualified health plan available to such individual.

(2) QUALIFIED EMPLOYER.—

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

(B) EMPLOYER MAY WITHIN A LEVEL.—Each employee of a qualified em-

ployer that elects a level of coverage under subparagraph (A) may choose to enroll in a qualified health plan that offers coverage at that level.

(C) PAYMENT OF PREMIUMS BY QUALIFIED IN-

DIVIDUALS.—A qualified individual enrolled in any qualified health plan may pay any ap-

licable premium owed by such individual to the health insurance issuer issuing such qualified health plan.

(d) EMPLOYER-APPOINTED RISK POOL.—

(1) INDIVIDUAL MARKET.—A health insur-

ance issuer shall consider all enrollees in all health plans (other than grandfathered health plans) to be individuals in the in-

dividual market, including those enrollees who do not enroll in such plans through the Exchange, to be members of a single risk pool.

(2) SMALL GROUP MARKET.—A health insur-

ance issuer shall consider all enrollees in all health plans (other than grandfathered health plans) to be individuals in the small group market, including those enrollees who do not enroll in such plans through the Exchange, to be members of a single risk pool.

(3) MERGER OF MARKETS.—A State may re-

quire the individual and small group insur-

ance markets within a State to be merged if the State determines appropriate.

(4) STATE LAW.—A State law requiring grandfathered health plans to be included in a pool described in paragraph (1) or (2) shall not apply.

(b) PROMOTING EMPLOYER CHOICE.—

(1) CONTINUOUS OPERATION OF MARKET OUT-

SIDE EXCHANGE.—Nothing in this title shall be

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

(1) QUALIFIED INDIVIDUALS.—In this title,

"qualified individual" means, with respect to an Exchange, an individual who—
(1) seeking to enroll in a qualified health plan in the individual market offered through the Exchange; and

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

(B) INCARCERATED INDIVIDUALS EXCLUDED.—An individual shall not be treated as a qualified health plan in the large group market in the State to offer qualified health plans in such market through an Exchange. Nothing in this subparagraph shall be construed as requiring the issuer to offer such plans through an Exchange.

(B) EXTENSION TO LARGE GROUPS.—

(1) IN GENERAL.—Beginning in 2017, each State may allow issuers of health insurance coverage in the large group market in the State to offer qualified health plans in such market through an Exchange. Nothing in this subparagraph shall be construed as requiring the issuer to offer such plans through an Exchange.

(2) LARGE EMPLOYERS ELIGIBLE.—If a State under clause (1) allows issuers to offer qualified health plans in the large group market through an Exchange, the term "qualified employer" shall include a large employer that elects to make all full-time employees of such employer eligible for 1 or more qualified health plans offered in the large group market through the Exchange.

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

SEC. 1313. FINANCIAL INTEGRITY.

(a) ACCOUNTING FOR EXPENDITURES.—

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

(2) AUDITS.—The Secretary, in coordination with the Inspector General of the Department of Health and Human Services, may investigate the affairs of an Exchange, may conduct a review of the audits and records of an Exchange, and may require periodic reports in relation to activities undertaken by an Exchange. An Exchange shall fully cooperate in any investigation conducted under this paragraph.

(3) AUDITS.—An Exchange shall be subject to annual audits by the Secretary.

(4) PREVENTION.—If the Secretary determines that an Exchange or a State has engaged in serious misconduct with respect to compliance with the requirements of, or carrying out of activities required under, this title, the Secretary may rescind from payments otherwise due to such State involved under this title or any other Act administered by the Secretary, an amount not to exceed 1 percent of such payments per year until corrective actions are taken by the State that are determined to be adequate by the Secretary.

(j) PROTECTIONS AGAINST FRAUD AND ABUSE.—With respect to activities carried out under this title, the Secretary shall provide for the detection and prevention of fraud and abuse, and ensure the proper administration of Exchange activities and implement any measures or procedure that—

(A) the Secretary determines is appropriate to reduce fraud and abuse in the administration of this title; and

(B) the Secretary has authority to require under any other Act administered by the Secretary.

(2) APPLICATION OF THE FALSE CLAIMS ACT.—

(A) IN GENERAL.—Payments made by, through, or in connection with an Exchange shall be subject to the False Claims Act (31 U.S.C. 3729 et seq.) if those payments include any Federal funds. Compliance with the requirements of this Act concerning eligibility for and payment of payments to participate in the Exchange shall be a material condition of an issuer’s entitlement to receive payments, including payments of premium tax credits and cost-sharing reductions, through the Exchange.

(B) DAMAGES.—Notwithstanding paragraph (1) of section 3729(a) of title 31, United States Code, and subject to paragraph (2) of such section, the civil penalty assessed under the False Claims Act on any person found liable under such Act as described in subparagraph (A) shall be increased by not less than 3 times and not more than 6 times the amount of damages which the Government sustains because of the act of that person.

(3) GD—FEDERAL PROGRAM TO ASSIST ESTABLISHED EXCHANGES.—

(A) IN GENERAL.—The Secretary may examine the properties and records of any private health insurance issuer that enters into a contractual agreement under section 1312(f).

(B) EXTENSION TO LARGE GROUPS.—

(1) IN GENERAL.—The term "qualified employer" shall include a large employer through an Exchange, and may require periodic review, examination, and may not be covered under a qualified health plan in the large group market offered through an Exchange that offers qualified health plans.

(2) EXTENSION TO LARGE GROUPS.—

(1) IN GENERAL.—An Exchange shall keep an accurate accounting of all activities, receipts, and expenditures and shall annually conduct an ongoing study of Exchange activities, including surveys and reports of the utilization and adoption of Exchanges; such study shall review—

(A) the operations and administration of Exchanges, including surveys and reports of qualified health plans offered through Exchanges and on the experience of such plans; (B) the enforcement of requirements of this Act concerning eligibility for and payment of payments to participate in Exchanges, including the extent to which Exchanges meet their goals; (C) the establishment and operation of Exchanges, including surveys and reports of the experience of such plans, and the manner in which Exchanges meet their goals; and

(D) any significant observations regarding the utilization and adoption of Exchanges; (E) where appropriate, recommendations for improvements in the operations or polices of Exchanges; and

(F) how many physicians, by area and specialty, are not taking or accepting new patients enrolled in Federal Government health care programs and the adequacy of provider networks of Federal Government health care programs.

PART III—STATE FLEXIBILITY RELATING TO EXCHANGES

SEC. 1321. STATE OPTION ON OPERATION AND ENFORCEMENT OF EXCHANGES AND RELATED REQUIREMENTS.

(a) ESTABLISHMENT OF STANDARDS.—

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

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

(B) the operation of qualified health plans through Exchanges;

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

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

The preceding sentence shall not apply to standards under subtitles A and C (and the amendments made by such subtitles) for which the Secretary issues regulations under the Public Health Service Act.

(2) CONSULTATION.—In issuing the regulations under paragraph (1), the Secretary shall consult with the National Association of Insurance Commissioners and its members and with health insurance issuers, consumer organizations, and other such individuals as the Secretary determines may be appropriate to ensure balanced representation among interested parties.

(b) STATE ACTION.—Each State that elects, at any time and in such manner as the Secretary may prescribe, to apply the requirements described in subsection (a) shall, not later than January 1, 2014, adopt and have in effect—

(1) the Federal standards established under subsection (a); or

(2) State law or regulation that the Secretary determines implements the standards within the State.

(c) FAILURE TO ESTABLISH EXCHANGE OR IMPLEMENT REQUIREMENTS.—

(1) IN GENERAL.—If—

(A) a State is not an electing State under subsection (b); or

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

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

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

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

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

the Secretary shall (directly or through agreements with a nonprofit, member-run health insurance issuer) establish and operate such Exchange within the State and the Secretary shall take such actions as are necessary to implement such other requirements.

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

(d) NO INTERFERENCE WITH STATE REGULATORY AUTHORITY.—Nothing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title.

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

(1) IN GENERAL.—In the case of a State operating an Exchange before January 1, 2010, and which has insured a percentage of its population not less than the percentage of the population projected to be covered nationally after the implementation of this Act, that seeks to operate an Exchange under this section, the Secretary shall presume that such Exchange meets the standards under this section unless the Secretary determines, after completion of the process established under paragraph (2), that the Exchange does not comply with such standards.

(2) PROCESS.—The Secretary shall establish a process to work with a State described in paragraph (1) to provide assistance necessary to ensure that the State’s Exchange in coming into compliance with the standards for approval under this section.

SEC. 1322. FEDERAL PROGRAM TO ASSIST ESTABLISHED AND OPERATION OF NON- PROFIT, MEMBER-RUN HEALTH INSURANCE ISSUERS.

(a) ESTABLISHMENT OF PROGRAM.—

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

(b) PURPOSE.—It is the purpose of the CO-OP program to foster the creation of nonprofit, member-run health insurance issuers to offer qualified health plans in the individual and small group markets in the States in
The Secretary shall notify the Secretary of the Treasury of any determination under this section of a failure that results in the termination of an issuer's tax-exempt status under section 501(c)(29) of such Code.  

(C) QUALIFIED NONPROFIT HEALTH INSURANCE ISSUER.—An organization shall not be treated as a qualified nonprofit health insurance issuer if—

(1) the organization is not organized under State law as a nonprofit, member corporation;  
(2) substantially all of the activities of the organization are providing health insurance to its members through a qualified nonprofit health insurer; and  
(3) the organization is not organized under State law as a nonprofit, member corporation, and has significant private support; and  
(4) the organization is not organized under State law as a nonprofit, member corporation.

(D) ESTABLISHMENT OF PRIVATE PURCHASING CO-OP PROGRAM.—The Secretary shall establish a private purchasing co-op program in each State that—

(1) IN GENERAL.—Qualified nonprofit health insurance issuers participating in the CO-OP program under this section may establish a private purchasing council to enter into collective purchasing arrangements for items and services that increase administrative and other cost efficiencies, including claims administration, patient services, health information technology, and actuarial services.

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

(3) CONTINUED APPLICATION OF ANTIATTACK LAWS.—

(A) IN GENERAL.—Nothing in this section shall be construed to limit the application of the antitrust laws to any private purchasing council constituted by the Secretary under this section.

(B) EXEMPTION FROM ANTIATTACK LAWS.—An organization established under this section and any other qualified nonprofit health insurance issuer may not be treated as an organization that is subject to the antitrust laws if—

(1) the organization is a qualified nonprofit health insurance issuer participating in the CO-OP program established under this section;

(2) the organization is a council under this section; and

(3) the organization is a qualified nonprofit health insurance issuer established under this section that—

(A) is organized under State law as a nonprofit, member corporation;  
(B) substantially all of the activities of the organization are providing health insurance to its members through a qualified nonprofit health insurer; and  
(C) is not organized under State law as a nonprofit, member corporation, and has significant private support; and  
(D) is not organized under State law as a nonprofit, member corporation.

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

(D) TERRITORIAL.—The advisory board shall meet on the earlier of the date that it completes its duties under this section or December 31, 2015.

The advisory board shall have such powers and duties as the Secretary may prescribe.
(B) establish or maintain a price structure for reimbursement of any health benefits covered by such issuers.

(2) COMPTROLLER.—Nothing in this section shall be construed as authorizing the Secretary to interfere with the competitive nature of providing health benefits through qualified nonprofit health insurance issuers.

(3) EFFECT.—There are hereby appropriated, out of any funds in the Treasury not otherwise appropriated, $6,000,000,000 to carry out this section.

(b) TAX EXEMPTION FOR QUALIFIED NONPROFIT HEALTH INSURER.—

(1) IN GENERAL.—Section 501(c) of the Internal Revenue Code (defining exempt organizations) is amended by adding at the end the following:

"(29) CO-OP HEALTH INSURANCE ISSUERS.—(A) In general.—A qualified nonprofit health insurance issuer (within the meaning of section 1322 of the Patient Protection and Affordable Care Act) which has received a loan or grant under the CO-OP program under this section, but only with respect to periods for which the issuer is in compliance with the requirements of such section and any agreement with respect to the loan or grant,

"(B) CONDITIONS FOR EXEMPTION.—Subparagraph (A) shall apply to an organization only if—

"(i) the organization has given notice to the Secretary, in such manner as the Secretary may provide, of its election to be a qualified health plan issuer under section 1322 of the Patient Protection and Affordable Care Act, no part of the net earnings of which inures to the benefit of any private shareholder or individual,

"(ii) including as part of the activities of which is carrying on propaganda, or otherwise attempting, to influence legislation, and

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

(2) ADDITIONAL REPORTING REQUIREMENT.—

Section 6033 of such Code (relating to returns required under subsection (a) the return required under subsection (a)(1), including any required under subsection (a)(2)), is amended by striking "paragraph (3), (4), (5), or (6)" and inserting "paragraph (3), (4), or (5)".

(3) APPLICATION OF TAX ON EXCESS BENEFIT DEDUCTION.—Section 4958(e)(1) of such Code (defining applicable tax-exempt organizations) is amended by redesignating paragraph (4) as paragraph (5) and by inserting after subsection (4) the following:

"(5) ADDITIONAL INFORMATION REQUIRED FROM CO-OP INSURERS.—An organization described in section 501(c)(29) shall include on the return required under subsection (a)(1) the following information:

"(1) The total amount of the reserves required by each State in which the organization is licensed to issue qualified health plans.

"(2) Amount of reserves on hand.

"(3) Application of tax on excess benefit transactions.—Section 4958(e)(1) of such Code (defining applicable tax-exempt organization) is amended by striking "paragraph (3) or (4)" and inserting "paragraph (3), (4), or (5)".

(4) GAO STUDY AND REPORT.

(1) IN GENERAL.—The Comptroller General of the General Accountability Office shall conduct an ongoing study on competition and market concentration in the health insurance market in the United States after the implementation of the reforms in such market under the provisions of, and the amendments made by, this Act. Such study shall include an analysis of new issuers of health insurance in such market.

(2) REPORT.—The Comptroller General shall, not later than December 31 of each even-numbered year, submit a report to the appropriate committees of the Congress containing the results of the study conducted under paragraph (1), including any recommendations for administrative or legislative changes that the Comptroller General determines necessary or appropriate to increase competition in the health insurance market.

SEC. 1233. COMMUNITY HEALTH INSURANCE OPT-ION.

(a) VOLUNTARY NATURE.—

(1) NO REQUIREMENT FOR HEALTH CARE PROVIDERS TO PARTICIPATE.—Nothing in this section shall be construed to require a State, a community health insurance issuer, or a health plan to participate in a community health insurance option, or to impose any penalty for non-participation.

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

(3) STATE OPT OUT.—(A) In general.—A State may elect to prohibit Exchanges in such State from offering a community health insurance option if such State enacts a law to provide for such prohibition.

(B) TERMINATION OF OPT OUT.—A State may repeal a law described in subparagraph (A) with the requirement of such section and any agreement with respect to such prohibition.

(4) CONGRESSIONAL RECORD — SENATE

November 19, 2009
(C) Consumer Protections.—The consumer protection laws of a State shall apply to a community health insurance option.

(B) Requirements Established in Partnership with State Commissioners.

(A) In General.—The Secretary, in collaboration with the National Association of Insurance Commissioners (in this paragraph referred to as "NAIC"), shall promulgate regulations to establish additional requirements for a community health insurance option.

(2) Applicability.—Any requirement promulgated under subparagraph (A) shall be applicable to such option beginning 90 days after the date on which the regulation involved goes into effect.

(c) Start-Up Fund.—

(1) Establishment of Fund.—

(A) In General.—There is established in the Treasury of the United States a trust fund to be known as the "Health Benefit Plan Start-Up Fund" (referred to in this section as the "Start-Up Fund").

(B) Use of Start-Up Fund.—

(2) Qualified Entity.—To be qualified to enter into a contract or contracts with one or more qualified entities for the purpose of performing administrative functions (including any functions relating to the securing of funds necessary for the implementation and enforcement of section 1874A of the Social Security Act) with respect to a community health insurance option under this section, the Secretary may enter into contracts under subsection (a)(1) of such section. The Secretary shall have the same authority with respect to a community health insurance option under this section as the Secretary has under subsections (a)(1) and (b) of section 1874A of the Social Security Act with respect to title XVIII of such Act.

(3) Requirements Apply.—If the Secretary enters into a contract with a qualified entity to offer a community health insurance option, under subsection (a)(1) of such section, the Secretary shall take into account any rebates or price concessions.

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

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

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

(7) Fee for Administration.—

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

(B) Requirement for High Quality Administration.—The Secretary shall be responsible for the fee described in subparagraph (A) by not more than 10 percent, or reduce the fee described in subparagraph (A) by not more than 10 percent, based on the extent to which the contracting administrator, in the determination of the Secretary, meets performance requirements established by the Secretary, in at least the following areas:

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

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

(iii) Promoting high quality clinical care.

(iv) Providing high quality customer service to beneficiaries.

(C) Non-Renewal.—The Secretary may not renew a contract to offer a community health insurance option under this section with any contracting entity that has been assessed more than one reduction under subparagraph (B) during the contract period.

(8) Limitation.—Notwithstanding the terms of a contract under this subsection, the Secretary shall negotiate the reimbursement rates for purposes of subparagraph (b)(2) during the contract period.

(9) Report by HHS and Insolvency Warnings.—

(A) In General.—On an annual basis, the Secretary shall conduct a study on the solvency of a community health insurance option and submit to Congress a report describing the results of such study.

(B) Submission of Plan and Procedure.—

(A) In General.—If there is a community health insurance option solvency warning, the Secretary shall conduct a competitive bidding process for the purposes of renewing existing contracts or selecting new qualified entities with which to enter into contracts under this section. Within 15 days of the President submitting to Congress, the Secretary shall conduct a competitive bidding process for the purposes of renewing existing contracts or selecting new qualified entities with which to enter into contracts under this section.
the budget submission to Congress under section 1105(a) of title 31, United States Code, for the succeeding year, proposed legislation to respond to such warning.

(b) In the case of a legislative proposal submitted by the President pursuant to subparagraph (A), such proposal shall be considered by Congress using the same procedures described under sections 803 and 804 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 that shall be used for a Medicare funding warning.

(g) Marketing Parity.—In a facility controlled by the Federal Government, or by a State, where marketing or promotional materials relating to private health insurance materials are made publicly available, making available marketing or promotional materials relating to private health insurance plans shall not be prohibited. Such materials include informational pamphlets, guidebooks, enrollment forms, or other materials determined reasonable for display.

(c) Authorization of Appropriations.—There is authorized to be appropriated such sums as may be necessary to carry out this section.

SEC. 1324. LEVEL PLAYING FIELD.

(a) In General.—Notwithstanding any other provision of law, any health insurance coverage offered by a private health insurance company that is subject to Federal or State law described in subsection (b) if a qualified health plan offered under the Consumer Operated and Oriented Plan program under section 1322, a community health insurance option under section 1323, or a nationalized qualified health plan under section 1333(b), is not subject to such law.

(b) Federal or State law described in subsection (a) if a qualified health plan offered under the program established under section 1322, a community health insurance option under section 1323, or a nationwide qualified health plan under section 1333(b), is not subject to such law.

(c) Federal or State laws in this subsection are those Federal and State laws relating to—

1) guaranteed renewal;
2) rating;
3) preexisting conditions;
4) non-discrimination;
5) quality improvement and reporting;
6) fraud and abuse;
7) solvency and financial requirements;
8) market conduct;
9) prompt payment;
10) non-discrimination in benefits;
11) privacy and confidentiality;
12) licensure; and
13) benefit plan material or information.

SEC. 1331. STATE FLEXIBILITY TO ESTABLISH ALTERNATIVE PROGRAMS.

(a) Establishment of Program.—

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

2) Certifications as to Benefit Coverage and Costs.—Such program shall provide that a State may not establish a basic health program under this section unless the State establishes to the satisfaction of the Secretary, and the Secretary certifies, that—

1) the amount of the monthly premium an eligible individual is required to pay for coverage under the standard health plan for the succeeding year, proposed legislation to respond to such warning.

(b) Federal or State laws in this subsection are those Federal and State laws relating to—

1) the case of an eligible individual enrolled in a standard health plan offered through an Exchange, the State provides—

1) that the amount of the monthly premium an eligible individual is required to pay for coverage under the standard health plan for the succeeding year, proposed legislation to respond to such warning.

2) (b) Authorization of Appropriations.—There is authorized to be appropriated such sums as may be necessary to carry out this section.

3) Marketing Parity.—In a facility controlled by the Federal Government, or by a State, where marketing or promotional materials relating to private health insurance plans shall not be prohibited. Such materials include informational pamphlets, guidebooks, enrollment forms, or other materials determined reasonable for display.

(c) Authorization of Appropriations.—There is authorized to be appropriated such sums as may be necessary to carry out this section.

SEC. 1324. LEVEL PLAYING FIELD.

(a) In General.—Notwithstanding any other provision of law, any health insurance coverage offered by a private health insurance company that is subject to Federal or State law described in subsection (b) if a qualified health plan offered under the Consumer Operated and Oriented Plan program under section 1322, a community health insurance option under section 1323, or a nationalized qualified health plan under section 1333(b), is not subject to such law.

(b) Federal or State law described in subsection (a) if a qualified health plan offered under the program established under section 1322, a community health insurance option under section 1323, or a nationwide qualified health plan under section 1333(b), is not subject to such law.

(c) Federal or State laws in this subsection are those Federal and State laws relating to—

1) guaranteed renewal;
2) rating;
3) preexisting conditions;
4) non-discrimination;
5) quality improvement and reporting;
6) fraud and abuse;
7) solvency and financial requirements;
8) market conduct;
9) prompt payment;
10) non-discrimination in benefits;
11) privacy and confidentiality;
12) licensure; and
13) benefit plan material or information.

SEC. 1331. STATE FLEXIBILITY TO ESTABLISH ALTERNATIVE PROGRAMS.

(a) Establishment of Program.—

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

2) Certifications as to Benefit Coverage and Costs.—Such program shall provide that a State may not establish a basic health program under this section unless the State establishes to the satisfaction of the Secretary, and the Secretary certifies, that—

1) the amount of the monthly premium an eligible individual is required to pay for coverage under the standard health plan for the succeeding year, proposed legislation to respond to such warning.

SEC. 1324. LEVEL PLAYING FIELD.

(a) In General.—Notwithstanding any other provision of law, any health insurance coverage offered by a private health insurance company that is subject to Federal or State law described in subsection (b) if a qualified health plan offered under the Consumer Operated and Oriented Plan program under section 1322, a community health insurance option under section 1323, or a nationalized qualified health plan under section 1333(b), is not subject to such law.

(b) Federal or State law described in subsection (a) if a qualified health plan offered under the program established under section 1322, a community health insurance option under section 1323, or a nationwide qualified health plan under section 1333(b), is not subject to such law.

(c) Federal or State laws in this subsection are those Federal and State laws relating to—

1) guaranteed renewal;
2) rating;
3) preexisting conditions;
4) non-discrimination;
5) quality improvement and reporting;
6) fraud and abuse;
7) solvency and financial requirements;
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2) Certifications as to Benefit Coverage and Costs.—Such program shall provide that a State may not establish a basic health program under this section unless the State establishes to the satisfaction of the Secretary, and the Secretary certifies, that—

1) the amount of the monthly premium an eligible individual is required to pay for coverage under the standard health plan for the succeeding year, proposed legislation to respond to such warning.
focus on enrollees with income below 200 percent of poverty.

(iii) Certification.—The Chief Actuary of the Centers for Medicare & Medicaid Services, in consultation with the Office of Tax Analysis of the Department of the Treasury, shall certify whether the methodology used to make determinations under this subparagraph, and such determinations, meet the requirements of clause (ii). Such certifications shall be based on sufficient data from the State and from comparable States about their experience with programs created by this Act.

(b) Corrections.—The Secretary shall adjust the payment for any fiscal year to reflect any error in the determinations under subparagraph (A) for any preceding fiscal year.

(4) Application of Special Rules.—The provisions of section 1303 shall apply to a State basic health program, and to standard health plans offered through such program, in the same manner as such rules apply to qualified health plans.

(e) Eligible Individual.—(1) In General.—In this section, the term "eligible individual" means, with respect to any State, an individual—

(A) who is a resident of the State who is not eligible to enroll in the State’s Medicaid program or the State plan under title XIX of the Social Security Act for benefits that at a minimum consist of the essential health benefits described in section 1302(b);

(B) whose household income exceeds 133 percent but does not exceed 200 percent of the poverty line for the size of the family involved;

(C) who is not eligible for minimum essential coverage (as defined in section 5000A(f) of the Internal Revenue Code of 1986) or is eligible for an employer-sponsored plan that is not affordable coverage (as determined under section 5000A(f) of such Code); and

(D) who has not attained age 65 as of the beginning of the plan year.

Such term shall not include any individual who is not a qualified individual under section 1312 who is eligible to be covered by a qualified health plan offered through an Exchange.

(2) Eligible Individuals May Not Use Exchange.—An eligible individual shall not be treated as a qualified individual under section 1312 who is eligible for enrollment in a qualified health plan offered through an Exchange established under section 1311.

(f) Secretarial Oversight.—The Secretary shall conduct a review of each State program to ensure compliance with the requirements of this section, including ensuring that the State program meets—

(1) eligibility verification requirements for participation in the program;

(2) requirements for use of Federal funds received by the program; and

(3) the quality and performance standards under this section.

(g) Standard Health Plan Offerings.—A State may provide that persons eligible to offer standard health plans under a basic health program established under this section may be eligible for enrollment in a qualified health plan offered through an Exchange established under section 1311.

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

SEC. 1332. WAIVER FOR STATE INNOVATION.

(a) In General.—(1) A State may apply to the Secretary for the waiver of all or any requirements described in paragraph (2) with respect to health insurance coverage within that State for plan years beginning on or after January 1, 2017. Such application shall—

(A) be filed at such time and in such manner as the Secretary may require; and

(B) contain such information as the Secretary may require, including—

(i) a comprehensive description of the State legislation and program to implement a plan meeting the requirements for a waiver under this section; and

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

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

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

(A) Part I of subtitle D.

(B) Part II of subtitle D.

(C) Section 1402.


(E) Pass Through of Funding.—With respect to a State waiver under paragraph (1), under which, due to the structure of the State plan, small employers in the State would not qualify for the premium tax credits, cost-sharing reductions, or small business credits under sections 36B of the Internal Revenue Code of 1986 or under part I of subtitle E for which they would otherwise be eligible, the Secretary shall provide for an alternative means by which the aggregate amount of such credits or reductions that would have been paid on behalf of participants in the Exchanges established under this title had the State not received such waiver shall be paid to the State for purposes of implementing the State plan under the waiver. Such amount shall be determined annually by the Secretary, taking into consideration the experience of other States with respect to participation in an Exchange and credits and reductions provided under such provisions to residents of the other States.

(2) Waiver Consideration and Transparency.—(A) In General.—An application for a waiver under this section shall be considered by the Secretary in accordance with the regulations described in subparagraph (B).

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

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

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

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

(II) the specific method by which the State to ensure that the waiver will be in compliance with subsection (b); and

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

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

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

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

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

(6) Definition.—In this section, the term "Secretary" means—

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

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

(b) Granting of Waivers.—(1) In General.—The Secretary may grant a waiver under this section only if the Secretary determines that the State plan—

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

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

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

(D) will not increase the Federal deficit.

(2) Requirement to Enact a Law.—(A) In General.—A law described in this paragraph is a State law that provides for State innovations under this section, including the implementation of the State plan under subsection (a)(1)(B).

(B) Termination of Opt-Out.—A State may request and the Secretary shall grant a law described in subparagraph (A) and terminate the authority provided under the waiver with respect to the State.

(c) Scope of Waiver.—(1) In General.—The Secretary shall determine the scope of a waiver of a requirement described in subsection (a)(2) granted to a State under subsection (a)(1).

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

(d) Determinations by Secretary.—(1) Time for Determination.—The Secretary shall make a determination under subsection (a)(1) not later than 180 days after the receipt of an application from a State under such subsection.

(2) Effect of Determination.—(A) Granting of Waivers.—If the Secretary determines to grant a waiver under subsection (a)(1), the Secretary shall notify the State involved of such determination and the terms and effectiveness of such waiver.

(B) Compliance with ACA.—The Federal law that established the Exchange for the State shall determine a waiver should not be granted under subsection (a)(1), the Secretary shall...
notify the State involved, and the appropriate committees of Congress of such determination and the reasons therefore.

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

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

(a) Health Care Choice Compacts.—

(1) IN GENERAL.—Not later than January 1, 2013, the Secretary shall, in consultation with the National Association of Insurance Commissioners, issue regulations for the creation of health care choice compacts under which 2 or more States may enter into an agreement under which—

(A) 1 or more qualified health plans could be offered in the individual markets in all such States but, except as provided in subparagraph (B), only be subject to the laws and regulations of the State in which the plan was written or issued;

(B) the issuer of any qualified health plan to which the compact applies—

(i) would be subject to market conduct, unfair trade practices, network adequacy, and consumer protection standards (including standards relating to rating), including but not limited to adjusting and maintaining community rating, which the purchaser resides;

(ii) would be required to be licensed in each State in which it offers the plan under the compact or to submit to the jurisdiction of each such State with regard to the standards described in clause (i) (including allowing access to records as if the insurer were licensed in the State); and

(iii) must clearly notify consumers that the policy may not be subject to all the laws and regulations of the State in which the purchaser resides.

(2) STATE AUTHORITY.—A State may not enter into an agreement under this section unless the State enacts a law after the date of enactment of this title pursuant to which the compact applies—

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

(B) the State laws that apply in each State in which it offers the plan and is subject to all requirements of State law not inconsistent with this section, including but not limited to the standards and requirements that a State imposes that do not prevent the application of a requirement of a law enacted after the date of enactment of this title;

(C) the issuer meets all requirements of this title with respect to a qualified health plan, including the requirement to offer the silver or gold levels of the plan in each exchange in the State in which the plan is offered;

(D) the issuer determines the premiums for the plan in any State on the basis of the rating rules in effect in that State for the rating areas in which it is offered;

(E) the issuer meets the requirements set forth in section 1334 with respect to the offering of a nationwide qualified health plan in at least 60 percent of the participating States in the first year in which the plan is offered, 65 percent of such participating States in the second year, 75 percent of such States in the third year, 75 percent of such States in the fourth year, and 80 percent of such States in the fifth and subsequent years;

(F) the issuer shall offer the plan in participating States across the country, in all geographic regions, and in all States that have adopted and maintained a community rating before the date of enactment of this Act; and

(G) the issuer clearly notifies consumers that the policy may not contain some benefits described in subsection (b); and

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

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

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

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

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

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

(B) the State laws that apply in each State in which it offers the plan and is subject to all requirements of State law not inconsistent with this section, including but not limited to the standards and requirements that a State imposes that do not prevent the application of a requirement of a law enacted after the date of enactment of this title.

(C) the issuer meets all requirements of this title with respect to a qualified health plan, including the requirement to offer the silver or gold levels of the plan in each exchange in the State in which the plan is offered;

(D) the issuer determines the premiums for the plan in any State on the basis of the rating rules in effect in that State for the rating areas in which it is offered;

(E) the issuer meets the requirements set forth in section 1334 with respect to the offering of a nationwide qualified health plan in at least 60 percent of the participating States in the first year in which the plan is offered, 65 percent of such participating States in the second year, 75 percent of such States in the third year, 75 percent of such States in the fourth year, and 80 percent of such States in the fifth and subsequent years;

(F) the issuer shall offer the plan in participating States across the country, in all geographic regions, and in all States that have adopted and maintained a community rating before the date of enactment of this Act; and

(G) the issuer clearly notifies consumers that the policy may not contain some benefits described in subsection (b); and

(4) FORM REVIEW FOR NATIONWIDE PLANS.—Notwithstanding any contrary provision of State law, any nationwide qualified health plan is offered, the issuer shall file all nationwide qualified health plan forms with the regulator in each participating State in which the plan is offered.

(5) RULES FOR THE OFFERING OF NATIONWIDE QUALIFIED HEALTH PLANS.—

(A) The Secretary shall, in consultation with the National Association of Insurance Commissioners, issue rules for the offering of nationwide qualified health plans.

(B) Nationwide qualified health plans may be offered only after such rules have taken effect.

(6) COVERAGES.—The Secretary shall provide that the health benefits coverage provided to an individual through a nationwide qualified health plan under this subsection shall include the essential benefits package described in section 1302.

(7) STATE LAW MANDATING BENEFIT COVERAGE BY A HEALTH BENEFITS PLAN.—For the purposes of this subsection, mandating benefit coverage by a health plan is a law that mandates health insurance coverage or the offer of health insurance coverage for services associated with certain classes of health care services, or a law that mandates that certain classes of individuals must be covered as a group or as dependents, is not a State law mandating benefit coverage by a health benefits plan.

PART V—REINSURANCE AND RISK ADJUSTMENT

SEC. 1341. TRANSITIONAL REINSURANCE PROGRAM FOR INDIVIDUAL AND SMALL GROUP MARKETS IN EACH STATE.

(a) IN GENERAL.—Each State shall, not later than January 1, 2014—

(1) include in the Federal standards or State law or regulation the State adopts and has in effect under section 1321(b) the provisions described in subparagraph (A) that apply to the establishment and maintain a program under which—

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

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

(2) HIGH-RISK INDIVIDUAL PAYMENT AMOUNTS.—The Secretary shall include the following in the provisions under paragraph (1):

(A) DETERMINATION OF HIGH-RISK INDIVIDUALS.—The method by which individuals will be identified as high-risk individuals for purposes of the reinsurance program established under this section. Such method shall provide for the identification of high-risk individuals as high-risk individuals on the basis of—

(i) a list of at least 50 but not more than 100 medical conditions that are identified as high-risk conditions and that may be based on the identification of diagnostic and procedure codes that are indicative of individuals with pre-existing, high-risk conditions; or

(ii) any other comparable objective method of identification recommended by the American Academy of Actuaries.

(B) PAYMENT AMOUNT.—The formula for determining the amount that will be paid to health insurance issuers described in paragraph (1)(A) that Insure high-risk individuals. Such formula shall provide for the equitable allocation of funds through reconciliation and may be designed—
(1) to provide a schedule of payments that specifies the amount that will be paid for each of the conditions identified under subparagraph (A); or
(2) to use any other comparable method for determining payment amounts that is recommended by the American Academy of Actuaries and that encourages the use of care management or other improvement programs for high-risk conditions.

(3) Determination of required contributions—

(A) In General.—The Secretary shall include in the provisions under paragraph (1) the method for determining the amount each health insurance issuer and any group health plan described in paragraph (1)(A) contributing to the reinsurance program under this section is required to contribute under such paragraph for each plan year beginning in the 36-month period beginning January 1, 2014. The contribution amount for any plan year may be based on the percentage of revenue of each issuer and the total costs of providing benefits to enrollees in self-insured plans or on a specified amount per enrollee and may be required to be paid in advance or periodically throughout the plan year.

(B) Specific requirements.—The method under this paragraph shall be designed so that—

(i) the contribution amount for each issuer proportionally reflects each issuer’s fully insured commercial book of business for all major medical products and the total value of all such business by the issuer and the costs of coverage administered by the issuer as a third party administrator;

(ii) the aggregate contribution amounts for all States shall, based on the best estimates of the NAIC and without regard to amounts described in clause (ii), equal $10,000,000,000 for plan years beginning in 2014, $6,000,000,000 for plan years beginning in 2015, and $4,000,000,000 for plan years beginning in 2016; and

(iv) in addition to the aggregate contribution amounts under clause (iii), each issuer’s contribution amount for any calendar year under clause (iii) reflects its proportionate share of $2,000,000,000 for 2014, an additional $2,000,000,000 for 2015, and an additional $1,000,000,000 for 2016.

Nothing in this subparagraph shall be construed to require a State from making additional amounts from issuers on a voluntary basis.

(4) Expenditure of funds.—The provisions under paragraph (1) shall provide that—

(A) the contribution amounts collected for any calendar year may be allocated and used in any of the three calendar years for which amounts are collected based on the reinsurance needs of a particular period or to reflect experience in a prior period; and

(B) amounts remaining unexpended as of December 31 of the year to be used to make payments under any reinsurance program of a State in the individual market in effect in the 2-year period beginning on January 1, 2017.

Notwithstanding the preceding sentence, any contribution amounts described in paragraph (3)(B)(iv) shall be deposited into the general fund of the States and shall not be used for the program established under this section.

(b) FEDERAL REINSURANCE ENTITY.—For purposes of this section—

(1) In General.—The term “applicable reinsurance entity” means a not-for-profit organization—

(A) the purpose of which is to help stabilize premiums for coverage in the individual and small group markets in a State during the first 3 years of operation of an Exchange for such markets within the State when the risk of adverse selection related to new rating rules and other changes in law and regulations results in an insufficient rate of return on capital; and

(B) the duties of which shall be to carry out the reinsurance program under this section by coordinating the funding and operations of the reinsurance program with the States designated to implement the reinsurance program.

(2) State discretion.—A State may have more than one applicable reinsurance entity to carry out the reinsurance program described in paragraph (1) if the State determines that having more than one applicable reinsurance entity is necessary to carry out the reinsurance program in the State.

(3) Entitlements are tax-exempt.—An applicable reinsurance entity established under this section shall be exempt from taxation under chapter 1 of the Internal Revenue Code of 1986. The preceding sentence shall not apply to the tax imposed by section 511 such Code (relating to tax on unrelated business taxable income of an exempt organization).

(c) Definitions.—In this section:

(1) Allowable costs.—

(A) In general.—The amount of allowable costs of a plan for any year is an amount equal to the total costs (other than administrative costs) of the plan in providing benefits covered by the plan.

(B) Reduction for risk adjustment and reinsurance payments.—Allowable costs shall be reduced by any risk adjustment and reinsurance payments received under section 1341 and 1343.

(2) Target amount.—The target amount of a plan for any year is the amount required to cover the total premiums (including any premium subsidies under any governmental program) reduced by the administrative costs of the plan.

(d) Risk adjustment.—

(1) In General.—

(A) Low actuarial risk plans.—Using the criteria and methods developed under subsection (b), each State shall establish a plan to participate in a payment adjustment system under which a qualified health plan offered in the individual and small group markets shall participate in a payment adjustment system based on the ratio of the allowable costs of the plan to the plan’s aggregate premiums. The Secretary may coordinate the State high-risk pool with such program to the extent not inconsistent with the provisions of this section.

(2) Establishment of risk corridors for plans in individual and small group markets.—

(a) In General.—There shall be estable and administer a program a risk corridors for calendar years 2014, 2015, and 2016 when a qualified health plan offered in the individual market in effect in a State for any year is an amount equal to the total costs (other than administrative costs) of the plan in providing benefits covered by the plan.

(b) Payment methodology.—

(1) Payments out.—The Secretary shall provide under the program established under subsection (a) that if—

(A) a participating plan’s allowable costs for any plan year are more than 103 percent but not more than 108 percent of the target amount, the plan shall pay to the plan’s aggregate premiums.

(B) a participating plan’s allowable costs for any plan year are more than 108 percent of the target amount, the Secretary shall pay to the plan an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of allowable costs in excess of 108 percent of the target amount.

(2) Payments in.—The Secretary shall provide under the program established under subsection (a) that if—

(A) a participating plan’s allowable costs for any plan year are less than 97 percent but not less than 92 percent of the target amount, the plan shall pay to the Secretary an amount equal to 50 percent of the excess of 97 percent of the target amount over the allowable costs; and

(B) a participating plan’s allowable costs for any plan year are less than 92 percent of the target amount, the plan shall eliminate or modify the plan.

(c) Scope.—A health plan or a health insurance issuer is described in this subsection if such plan or issuer—

(i) provides coverage in the individual or small group market within the State. This subsection shall not apply to a grandfathered health plan or the issuer of a grandfathered health plan with respect to that plan.

Subtitle E—Affordable Coverage Choices for All Americans

PART I—Premium Tax Credits and Cost-Sharing Reductions

Subpart A—Premium Tax Credits and Cost-Sharing Reductions

SEC. 1401. REFUNDABLE TAX CREDIT PROVIDING PREMIUM ASSISTANCE FOR COVERAGE UNDER A QUALIFIED HEALTH PLAN.

(a) In General.—Subpart C of part IV of chapter 1 of the Internal Revenue Code of 1986 (relating to refundable credits) is amended by inserting after section 36A the following new section:

“SEC. 36B. REFUNDABLE CREDIT FOR COVERAGE UNDER A QUALIFIED HEALTH PLAN.

“(1) IN GENERAL.—In the case of an applicable taxpayer, there shall be allowed as a credit against the tax imposed by this subtitle for any taxable year an amount equal to the premium assistance credit amount of the applicable taxpayer for the tax year for which the credit is allowed. “(b) PREMIUM ASSISTANCE CREDIT AMOUNT.—For purposes of this section—

to 1 of the spouses by reason of subsection (e), the taxpayer shall be treated as described in clause (i)(I) unless a deduction is allowed under section 151 for the taxable year with respect to any premium the taxpayer or the taxpayer’s spouse and subsection (e) does not apply to the dependent.

(2) ADJUSTED PREMIUM.—The adjusted monthly premium for an applicable second lowest cost silver plan is the monthly premium which would have been charged (for purposes of section 151) to the taxpayer under paragraph (2)(A) were determined for the plan if each individual covered under a qualified health plan taken into account under paragraph (2)(A) were covered by such silver plan and the premium was adjusted only for the age of each such individual taken into account under section 2701 of the Public Health Service Act. In the case of an individual participating in the wellness discount demonstration project under section 1302(b)(2) of the Public Health Service Act, the adjusted monthly premium shall be determined without regard to any premium discount or rebate under such project.

(3) CREDIT.—(A) IN GENERAL.—The term ‘premium assistance credit amount’ means, with respect to an applicable taxpayer, any month if—

(i) as of the first day of such month the taxpayer, the taxpayer’s spouse, or any dependent of the taxpayer is covered by a qualified health plan described in subsection (b)(2)(A) that was enrolled in through an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act, and

(ii) the coverage month shall not include any month with respect to an individual if for such month the individual is eligible for minimum essential coverage other than employer-sponsored coverage described in section 5000A(f)(1)(C) (relating to coverage in the individual market).

(B) EXCEPTION FOR MINIMUM ESSENTIAL COVERAGE.—The term ‘minimum essential coverage’ has the meaning given such term by section 5000A(f)(1)(C).

(C) SPECIAL RULE FOR EMPLOYER-SPO evidence of health plan coverage (as defined in such section that (under regulations prescribed by the Secretary of Health and Human Services) is properly allocable to the taxpayer. In the case of a State participating in the wellness discount demonstration project under section 1302(b)(2) of the Public Health Service Act, the adjusted monthly premium for an applicable second lowest cost silver plan shall be determined under this subsection with respect to any coverage month in which the taxpayer has made no election for such month.
(3) Definitions and other rules.—

(A) QUALIFIED HEALTH PLAN.—The term ‘qualified health plan’ has the meaning given such term by section 1301(a) of the Patient Protection and Affordable Care Act, except that such term shall not include a qualified health plan which is a catastrophic plan described in section 1302(e) of such Act.

(B) GRANDFATHERED HEALTH PLAN.—The term ‘grandfathered health plan’ has the meaning given such term by section 1251 of the Patient Protection and Affordable Care Act.

(d) Terms relating to income and families.—For purposes of this section—

(1) FAMILY SIZE.—The family size involved with respect to any taxpayer shall be equal to the number of individuals for whom the taxpayer is allowed a deduction under section 151 (relating to allowance for personal exemptions) for the taxable year.

(2) HOUSEHOLD INCOME.—

(A) HOUSEHOLD INCOME.—The term ‘household income’ means, with respect to any taxpayer, an amount equal to the sum of—

(i) the modified gross income of the taxpayer, plus

(ii) aggregate modified gross incomes of all other individuals who—

(I) were taken into account in determining the taxpayer’s family size under paragraph (A), and

(II) were required to file a return of tax imposed by section 1 for the taxable year.

(B) MODIFIED GROSS INCOME.—The term ‘modified gross income’ means gross income—

(i) decreased by the amount of any deduction allowable under paragraph (1), (3), (4), or (16) of section 62, and

(ii) increased by the amount of interest received or accrued during the taxable year which is exempt from tax imposed by this chapter.

(2) INDEXING OF AMOUNT.—

(i) IN GENERAL.—In the case of an applicable taxpayer, the amount of modified gross income under paragraph (A) shall in no event exceed $400 for the taxable year.

(ii) INDEXING OF AMOUNT.—In the case of an applicable taxpayer, the amount of modified gross income under paragraph (A) shall in no event exceed $400 for the taxable year.

(B) POVERTY LINE USED.—In the case of any individual who is not lawfully present under section 45B of the Internal Revenue Code of 1986 and the tax credit for employee health insurance expenses of small employers under section 45R of such Code on maintaining and expanding the health insurance coverage of individuals,

(ii) the availability of affordable health benefits plans, including a study of whether the percentage of household income used for the purpose of section 1324(c) of the Internal Revenue Code of 1986 (as added by this section) is the appropriate level for determining whether employer-provided coverage is affordable for an individual and whether such level may be lowered without significantly increasing the costs to the Federal Government and reducing employer-provided coverage; and

(iii) the ability of individuals to maintain essential health benefits coverage (as defined in section 5000A(f) of the Internal Revenue Code of 1986).

(B) REPORT.—The Comptroller General shall submit to the appropriate committees of Congress a report on the affordability of health insurance coverage, including—

(1) the impact of the tax credit for qualified health insurance coverage of individuals under section 36B of the Internal Revenue Code of 1986 and the tax credit for employee health insurance expenses of small employers under section 45R of such Code on maintaining and expanding the health insurance coverage of individuals;

(2) the ability of affordable health benefits plans, including a study of whether the percentage of household income used for the purpose of section 1324(c) of the Internal Revenue Code of 1986 (as added by this section) is the appropriate level for determining whether employer-provided coverage is affordable for an individual and whether such level may be lowered without significantly increasing the costs to the Federal Government and reducing employer-provided coverage; and

(3) the ability of individuals to maintain essential health benefits coverage (as defined in section 5000A(f) of the Internal Revenue Code of 1986).

(c) Conforming amendments.—

(1) Paragraph (2) of section 1324(b) of title 31, United States Code, as amended by inserting “36B,” after “36A.”.

(2) The table of sections for subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after the item relating to section 36A the following new item:

Sec. 36B. Refundable credit for coverage under a qualified health plan.

(e) Effective date.—The amendments made by this section shall apply to taxable years beginning after December 31, 2013.
(2) whose household income exceeds 100 percent but does not exceed 400 percent of the poverty line for a family of the size involved.

In the case of an individual described in section 36B(e)(1)(B) of the Internal Revenue Code of 1986, the individual shall be treated as having household income equal to 100 percent for purposes of applying this section.

c) **Termination of Reduction in Cost-Sharing.—**

(1) **Reduction in Out-of-Pocket Limit.—**

(A) In general.—The reduction in cost-sharing under this subsection shall not be achieved by reducing the applicable out-of-pocket limit under section 1320(c)(1) in the case of—

(1) an eligible insured whose household income is more than 100 percent but not more than 200 percent of the poverty line for a family of the size involved, by two-thirds; and

(ii) an eligible insured whose household income is more than 200 percent but not more than 300 percent of the poverty line for a family of the size involved, by one-third.

(B) Coordination with Actuarial Value Limits.—

(i) In general.—The Secretary shall ensure that the reductions under this paragraph shall not result in an increase in the plan’s share of the total allowed costs of benefits provided under the plan above—

(1) 50 percent in the case of an eligible insured described in paragraph (2)(A);

(II) 80 percent in the case of an eligible insured described in paragraph (2)(B); and

(III) 70 percent in the case of an eligible insured described in clause (1) or (II) of subparagraph (A).

(ii) Adjustment.—The Secretary shall adjust the out-of-pocket limits under paragraph (1) if necessary to ensure that such limits do not cause the respective actuarial values to exceed the levels specified in clause (I).

(2) **Additional Reduction for Lower Income Insureds.—**

The Secretary shall establish procedures under which the issuer of a qualified health plan making reductions under this subsection applies shall further reduce cost-sharing under the plan in a manner sufficient to—

(A) in the case of an eligible insured whose household income is less than 100 percent but not more than 150 percent of the poverty line for a family of the size involved, increase the plan’s share of the total allowed costs of benefits provided under the plan to 90 percent of such costs; and

(B) in the case of an eligible insured whose household income is more than 150 percent but not more than 200 percent of the poverty line for a family of the size involved, increase the plan’s share of the total allowed costs of benefits provided under the plan to 80 percent of such costs.

(3) **Methods for Reducing Cost-Sharing.—**

(A) In general.—An issuer of a qualified health plan making reductions under this subsection shall notify the Secretary of such reductions and the Secretary shall make periodic and timely payments to the issuer equal to the value of the reductions.

(B) The Secretary may establish a capitated payment system to carry out the payment of cost-sharing reductions under this subsection. Any such system established by the Secretary of such reductions and make appropriate risk adjustments to such payments.

(C) **Additional Benefits.—**If a qualified health plan under section 1311(d)(3)(B) to cover benefits in addition to the essential health benefits required to be provided by the plan, or a State requires a qualified health plan under section 1311(d)(3)(B) to cover benefits in addition to the essential health benefits required to be provided by the plan, the reductions in cost-sharing under this section shall not apply to such additional benefits.

(5) **Special Rule for Pediatric Dental Plans.—**If an individual enrolls in both a qualified health plan described in section 1311(d)(2)(B)(ii)(I)(i) for any plan year, subsection (a) shall not apply to that portion of any reduction in cost-sharing under subsection (c) that (under regulations prescribed by the Secretary) is properly allocable to pediatric dental benefits which are included in the essential health benefits required to be provided by a qualified health plan under section 1302(b)(1)(J).

(6) **Special Rules for Indians.—**

(1) **Indian Eligentment of Poverty.—**If an individual enrolled in any qualified health plan in the individual market through an Exchange is an Indian (as defined in section 4(d) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(i)) whose household income is not more than 300 percent of the poverty line for a family of the size involved, then, for purposes of this section—

(A) such individual shall be treated as an eligible insured; and

(B) the issuer of the plan shall eliminate any cost-sharing under the plan.

(2) **Items or Services Furnished Through Indian Health Service.—**If an Indian (as so defined) enrolled in a qualified health plan is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services—

(A) no cost-sharing under the plan shall be imposed under the plan for such item or service; and

(B) the issuer of the plan shall not reduce the payment to any such entity for such item or service by the amount of any cost-sharing that would be due from the Indian but for subparagraph (A).

(3) **Payment.—**The Secretary shall—

(A) pay to the issuer of a qualified health plan the amount necessary to reflect the increase in actuarial value of the plan required by reason of the reductions under this section;

(B) establish a program meeting the requirements of this subsection; and

(C) Rules for Individuals Not Lawfully Present.—

(1) **In general.—**If an individual who is an eligible insured for purposes of this section is not lawfully present—

(A) no cost-sharing reduction under this section shall apply with respect to the individual; and

(B) for purposes of applying this section, the determination as to what percentage a taxpayer’s household income bears to the poverty level for a family of the size involved shall be made under one of the following methods:

(i) A method under which—

(II) the taxpayer’s household income is determined by not taking such individuals into account, and

(II) the taxpayer’s household income is equal to the product of the taxpayer’s household income (determined without regard to this subsection) and a fraction—

(aa) the numerator of which is the poverty line for the taxpayer’s family size determined under subsection (c) (or, if the taxpayer is not a naturalized citizen, the amount necessary to reflect the increase in actuarial value of the plan required by reason of this subsection) and a fraction—

(bb) the denominator of which is the poverty line for the taxpayer’s family size determined without regard to clause (I); and

(ii) A method accomplishing the same result as the method under clause (i).

(2) **Lawfully Present.—**For purposes of this section, an individual shall be treated as lawfully present if the individual is, and is reasonably expected to be for the entire period of enrollment for which the cost-sharing reduction under this section is being claimed, a citizen or national of the United States or an alien lawfully present in the United States.

(6) **Definitions and Special Rules.—**In this section:

(1) **In General.—**Any term used in this section which is also used in section 36B of the Internal Revenue Code of 1986 shall have the meaning given such term by such section.

(2) **Limitations on Reduction.—**No cost-sharing reduction shall be allowed under this section with respect to coverage for any month unless the month is a coverage month with respect to which a credit is allowed to the insured (or an applicable taxpayer on behalf of the insured) under section 36B of such Code.

(3) **Data Used for Eligibility.—**Any determination under this section shall be made on the basis of the taxable year for which the advance determination is made under section 1412 and not the taxable year for which the credit under section 36B of such Code is allowed.

Subpart B—Eligibility Determinations

**SEC. 1411. PROCEDURES FOR DETERMINING ELIGIBILITY FOR EXCHANGE PARTICIPATION, PREMIUM TAX CREDITS AND REDUCED COST-SHARING, AND INDIVIDUAL RESPONSIBILITY EXEMPTIONS.—**

(a) **Establishment of Program.—**The Secretary shall establish a program meeting the requirements of this section for determining—

(1) whether an individual who is to be covered in the individual market by a qualified health plan offered through an Exchange, or who is claiming a premium tax credit or reduced cost-sharing, meets the requirements of sections 1412(f)(3), 1402(e), and 1412(d) of this title and section 36B(e) of the Internal Revenue Code of 1986 that the individual be a citizen or national of the United States or an alien lawfully present in the United States;

(2) in the case of an individual claiming a premium tax credit or reduced cost-sharing under section 36B of such Code or section 1402—

(A) whether the individual meets the income and coverage requirements of such sections; and

(B) the amount of the tax credit or reduced cost-sharing;

(3) whether an individual’s coverage under an employer-sponsored health benefits plan is treated as unavailable under sections 36B(c)(2)(C) and 5000A(e)(2); and

(4) whether to grant a certification under section 1311(d)(4)(D) attesting that, for purposes of the individual responsibility requirement under section 5000A of the Internal Revenue Code of 1986, an individual is entitled to an exemption from either the individual responsibility requirement or the penalty imposed by such section.

(b) **Information Required To Be Provided By Applicants.—**

(1) **In General.—**An applicant for enrollment in a qualified health plan offered through an Exchange in the individual market shall—

(A) the name, address, and date of birth of each individual who is to be covered by the
eligibility, on an attestation of citizenship of the enrollee, the enrollee’s social security number (if applicable) and such other information as the Secretary determines appropriate.

(2) CITIZENSHIP OR IMMIGRATION STATUS.—The following information shall be provided with respect to every enrollee:

(A) in the case of an individual whose eligibility is based on an attestation of citizenship of the enrollee, the enrollee’s social security number (if applicable) and such other information as the Secretary determines appropriate.

(B) in the case of an individual whose eligibility is determined in the same manner as an individual whose immigration status as the Secretary, after consultation with the Secretary of Homeland Security, determines appropriate.

(c) VERIFICATION OF INFORMATION CONTAINED IN RECORDS OF SPECIFIC FEDERAL OFFICER.—The Secretary shall verify the following:

(1) INFORMATION TRANSFERRED TO SECRETARY.—An Exchange shall submit the information provided by an applicant under subsection (b) and described in subparagraph (A) to the Secretary for verification in accordance with the requirements of subsection (b).

(2) CITIZENSHIP OR IMMIGRATION STATUS.—

(A) COMMISSIONER OF SOCIAL SECURITY.—The Secretary shall submit to the Commissioner of Social Security the following information for a determination as to whether the information provided is consistent with the information in the records of the Commissioner:

(i) The name, date of birth, and social security number of such individual for whom such information was provided under subsection (b)(2).

(ii) The attestation of an individual that the individual is a citizen.

(B) SECRETARY OF HOMELAND SECURITY.—

(i) IN GENERAL.—In the case of an individual:

(I) who attests that the individual is an alien lawfully present in the United States; or

(II) who attests that the individual is an alien lawfully present in the United States; and

(ii) the Secretary shall, if applicable, notify the Exchange and the Exchange shall notify the Secretary of the Treasury, the Secretary of Homeland Security, or the Commissioner of Social Security through such other method as is approved by the Secretary.

The Secretary may modify the methods used under the program established by this section for the Exchange and verification of information if the Secretary determines such modifications would reduce the administrative costs and burdens on the applicant, including allowing an applicant to request the Secretary of the Treasury to provide the information described in paragraph (3) directly to the Exchange or to the Secretary. The Secretary shall not make any such modification unless the Secretary determines such modifications are necessary to reduce the administrative costs and burdens on the applicant and will reduce such costs and burdens to the extent practicable, including delegating responsibility for verification to the Exchange.

(e) ACTIONS RELATING TO VERIFICATION.—

(1) IN GENERAL.—If information provided under subsection (b) is verified under subsections (c) and (d), the Secretary shall notify the Secretary of the Treasury of the amount of any advance payment to be made.

(2) VERIFICATION.—

(A) ELIGIBILITY FOR ENROLLMENT AND PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS.—If information provided by an applicant under paragraphs (1), (2), (3), and (4) of subsection (b) is verified under subsections (c) and (d), the Secretary shall notify the Exchange and the Exchange shall notify the Secretary of the amount of any advance payment to be made.

(B) EXEMPTION FROM INDIVIDUAL RESPONSIBILITY.—If information provided by an applicant under subsection (b) is verified under subsections (c)(1) or (4), the Secretary shall issue the certification of exemption described in section 1311(d)(4)(H).

(3) INCOMPLIANCE WITH ATTERTATION OF CITIZENSHIP OR LAWFUL PRESENCE.—If the information provided by any applicant under subsection (b)(2) is inconsistent with information in the records maintained by the Commissioner of Social Security or the Secretary of Homeland Security, whichever is applicable, the applicant’s eligibility will be determined in the same manner as an individual’s eligibility under the medicare program is determined under section 1902(ee) of the Social Security Act (as in effect on January 1, 2010).

(4) INCORRECTNESS OF INFORMATION.—

(A) IN GENERAL.—If the information provided by an applicant under subsection (b) (other than subsection (b)(2)) is inconsistent with information in the records maintained by persons under subsection (c) or is not maintained by the Secretary, the Secretary shall notify the Exchange and the Exchange shall take the following actions:
(1) **Reasonable Effort.**—The Exchange shall make a reasonable effort to identify and address the causes of such inconsistency, including through typographical or other clerical errors of the Exchange; and be notified of the inconsistency to the extent necessary in, and by taking such additional actions as the Secretary, through regulation or other guidance, may prescribe.

(ii) **Notice and Opportunity to Correct.**—In the case the inconsistency or inability to verify is not resolved under subparagraph (A), the Exchange shall—

(I) notify the applicant of such fact;

(II) provide the applicant an opportunity to either present satisfactory documentary evidence or resolve the inconsistency with the person verifying the information under subsection (c) or (d) during the 90-day period beginning the date on which the notice required under subclause (I) is sent to the applicant.

The Secretary may extend the 90-day period under subclause (II) for enrollments occurring during 2014.

(B) **Specific Actions Not Involving Citizenship or Lawful Presence.**—

(I) In General. —As except as provided in paragraph (3), the Exchange shall, during any period the Exchange is collecting the information under subparagraph (A)(ii)(II), make any determination under paragraphs (2), (3), and (4) of subsection (g) based on the information contained on the application.

(ii) **Eligibility or Amount of Credit or Reduction.** —If an inconsistency involving the eligibility for, or amount of, any premium tax credit or cost-sharing reduction is unresolved under this subsection as of the close of the period under subparagraph (A)(ii)(II), the Exchange shall notify the applicant of the amount (if any) of the credit or reduction that is determined to be the extent allowable by law.

Such process shall be in addition to any rules of appeal the employer may have under subtitle F of such Code.

(C) **Confidentiality.** —Notwithstanding any provision of this title or the amendments made by this title or section 6103 of the Internal Revenue Code of 1986, an employer—

(I) shall not provide any taxpayer return information with respect to an employee for purposes of determining whether the employer is subject to the penalty under section 4980H of such Code with respect to the employee, except that—

(1) the employer may be notified as to the name of an employee and whether or not the employee’s income is above or below the threshold by which the affordability of an employer’s health insurance coverage is measured; and

(2) the Exchange shall not apply to an employee who provides a waiver (at such time and in such manner as the Secretary may prescribe) authorizing the employer to have access to the employee’s taxpayer return information.

(D) **Confidentiality of Applicant Information.**—

(I) In General. —An applicant for insurance coverage or for a premium tax credit or cost-sharing reduction shall be required to provide only the information strictly necessary to authenticate identity, determine eligibility, and determine the amount of the credit or reduction.

(II) **Receipt of Information.** —Any person who receives information provided by an applicant under subsection (b) (whether directly or by another person at the request of the applicant), or receives information from a Federal agency under subsection (c), (d), or (e), shall—

(A) use the information only for the purposes of, and to the extent necessary in, enforcing the efficient operation of the Exchange, including verifying the eligibility of an individual to enroll through an Exchange or to claim a premium tax credit or cost-sharing reduction; and

(B) not disclose the information to any other person except as provided in this section.

(E) **Penalties.**—

(I) **False or Fraudulent Information.**—

(A) Civil Penalties. —

(I) In General.—

(1) any person fails to provide correct information under subsection (b); and

(2) such failure is attributable to negligence or disregard of any rules or regulations of the Exchange, such person shall be subject, in addition to any other penalties that may be prescribed by law, to a civil penalty of not more than $25,000 with respect to any failures involving an application for a plan year. For purposes of this subparagraph, the terms “negligence” and “disregard” shall have the same meanings as when used in section 6662 of the Internal Revenue Code of 1986.

(B) Knowing and Willful Violations.—Any person who knowingly and willfully provides false or fraudulent information under this paragraph (I), shall be subject to any other penalties that may be prescribed by law, to a civil penalty of not more than $25,000.

(II) Improper Use or Disclosure of Information.—Any person who knowingly and willfully uses or discloses information in violation of subsection (c) shall be subject, in addition to any other penalties that may be prescribed by law, to a civil penalty of not more than $25,000.

(F) **Limitations on Liens and Levies.** —The Secretary (or, if applicable, the Attorney General of the United States) shall not—

(A) file notice of lien with respect to any property of a person because of any failure to pay the penalty imposed by this subsection; or

(B) levy on any such property with respect to such failure.

(i) **Study of Administration of Employer Responsibility.**—

(I) In General. —The Secretary of Health and Human Services shall, in consultation with the Secretary of the Treasury, conduct a study of the procedures that are necessary to ensure that in the administration of this title and section 4980H of the Internal Revenue Code of 1986 (as added by section 1513) that the following rights are protected:

The rights of employers to adequate due process and access to information necessary to accurately determine any payment assessed on employers.

(B) the rights of employers to adequate due process and access to information necessary to accurately determine any payment assessed on employers.

(1) Report. —Not later than January 1, 2013, the Secretary of Health and Human Services shall report the results of the study conducted under paragraph (1), including any recommendations for legislative changes, to the Committees on Finance and Health, Education, Labor, and Pensions and the Committees of Education and Labor and Ways and Means of the House of Representatives.

SEC. 1412. ADVANCE DETERMINATION AND PAYMENT OF PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS.

(a) In General. —The Secretary, in consultation with the Treasury, shall establish a program under which—

(I) upon request of an Exchange, advance determinations are made in reason to the income eligibility of individuals enrolling in a qualified health plan in the individual market through the Exchange for the premium tax credit allowable under section 36B of the Internal Revenue Code of 1986 and the cost-sharing reductions under section 1402;

(II) the Secretary notifies—

(A) the Exchange and the Secretary of the Treasury of the advance determinations; and

(B) the Secretary of the Treasury of the number of each employer with respect to whom 1 or more employees of the employer were determined to be eligible for the premium tax credit allowable under section 36B of the Internal Revenue Code of 1986 and the cost-sharing reductions under section 1402;
(i) the employer did not provide minimum essential coverage; or
(ii) the employer provided such minimum essential coverage but it was determined under subparagraph (C) of such subsection that it was not affordable to the employee;

(3) Cost-Sharing Reductions.—The Secretary shall also notify the Secretary of the Treasury and the Exchange in writing under section 1411(c)(2)(A) if an advance payment of cost-sharing reductions under this section is provided to the issuer of any qualified health plan with respect to any individual enrolled in such plan. The Secretary of the Treasury shall make such notification at the same time and in such amount as the Secretary specifies in the notice.

(a) In General.—The Secretary shall establish a streamlined form that—
(i) may be used to apply for all applicable State health subsidy programs; and
(ii) may be filed online, in person, by mail, or by telephone;

(b) Payment of Premium Tax Credits and Cost-Sharing Reductions.—

(1) In General.—The Secretary shall make advance payments of such credit or reductions to the issuer of the qualified health plan in order to reduce premiums payable by eligible individuals.

(2) Premium Tax Credit.—

(A) In General.—The Secretary shall establish procedures for making advance payments on the basis of information other than that described in paragraph (1)(B) in cases where information included with an application form demonstrates, on the basis of changes in household circumstances, changes in filing status, the filing of an application for unemployment benefits, or other significant changes affecting eligibility, including—

(i) allowing an individual claiming a decrease of 20 percent or more in income, or filing a claim for unemployment benefits, to be eligible for the credit determined on the basis of household income for a later period or on the basis of the individual’s estimate of such income for the taxable year; and

(ii) the determination of household income in cases where the taxpayer was not required to file a return of tax imposed by this chapter for the preceding taxable year.

(c) Payment of Premium Tax Credits and Cost-Sharing Reductions.—

(1) In General.—The Secretary shall notify the Secretary of the Treasury and the Exchange through which the individual is enrolling of the advance determination under section 1411(c)(2)(A) or (B).

(2) Premium Tax Credit.—

(A) In General.—The Secretary shall make the advance payment under this section of any premium tax credit allowed under section 36B of the Internal Revenue Code of 1986 to the issuer of a qualified health plan, as defined in such section, for the taxable year.

(B) Issuer Responsibilities.—An issuer of a qualified health plan receiving an advance payment with respect to an individual enrolled in the plan shall—

(i) reduce the premium charged the insured for any period by the amount of the advance payment for the period;

(ii) notify the Exchange and the Secretary of such reduction;

(iii) include with each billing statement the amount by which the premium for the plan has been reduced by reason of the advance payment; and

(iv) verify any nonpayment of premiums by the insured—

(I) notify the Secretary of such nonpayment; and

(II) in the case of any 3-month grace period for nonpayment of premiums before discontinuing coverage.
(A) prohibit contractual arrangements through which a State Medicaid agency determines eligibility for all applicable State health subsidy programs, but only if such agencies establish and maintain written policies and procedures ensuring reduced administrative costs, eligibility errors, and disruptions in coverage; or

(B) impose any requirement under title XIX that eligibility for participation in a State’s Medicaid program must be determined in a particular way.

c) APPLICABLE STATE HEALTH SUBSIDY PROGRAM.—In this section, the term ‘applicable State health subsidy program’ means—

(1) the program under this title for the enrollment in qualified health plans offered through an Exchange, including the premium tax credits and cost-sharing reductions under section 1401.

(2) a State Medicaid program under title XIX of such Act; and

(3) a State children’s health insurance program (CHIP) under title XXI of such Act.

SEC. 1414. DISCLOSURE TO EMPLOYERS OF ELIGIBILITY OR PREMIUM SUBSIDY OR COST-SHARING REDUCTION.

(a) DISCLOSURE TO EMPLOYERS OF ELIGIBILITY OR PREMIUM SUBSIDY OR COST-SHARING REDUCTION.—Subsection (l) of section 6103 of the Internal Revenue Code of 1986 is amended by adding at the end the following new clause:

‘‘(n) establishment eligibility for participation in the Exchange and verifying the appropriate amount of any credit or reduction described in subparagraph (A),’’.

‘‘(i) determining eligibility for participation in the State programs described in subparagraph (A),’’.

(2) SOCIAL SECURITY NUMBERS.—Section 205(c)(2)(C) of the Social Security Act is amended by adding at the end the following new clause:

‘‘(x) the Secretary of Health and Human Services, and the Exchanges established under section 1311 of the Patient Protection and Affordable Care Act, are authorized to collect and use the names and social security account numbers of individuals as required to administer the Act and the amendments made by the, the Act.’’

(b) CONFIDENTIALITY AND DISCLOSE.—Paragraph (3) of section 6103(a) of such Code is amended—

(1) by inserting ‘‘, or any entity described in subparagraph (A),’’ after ‘‘or (20)’’ in the matter preceding subparagraph (A),

(2) by inserting ‘‘, or any entity described in subparagraph (I)(a),’’ after ‘‘or (20)’’ in subparagraph (F)(I), and

(3) by inserting ‘‘, or any entity described in subparagraph (I)(a),’’ after ‘‘or (20)’’ both places it appears in the matter after subparagraph (F).

(d) UNAUTHORIZED DISCLOSURE OR INSPECTION.—Paragraph (2) of section 7213(a) of such Code is amended by striking ‘‘(20)’’.

SEC. 1415. PREMIUM TAX CREDIT AND COST-SHARING REDUCTIONS FOR ELIGIBLE SMALL EMPLOYERS.

(a) GENERAL.—Subpart D of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to business-related credits) is amended by inserting after section 45Q the following:

‘‘SEC. 45R. EMPLOYEE HEALTH INSURANCE EXCHANGE CREDITS FOR ELIGIBLE SMALL EMPLOYERS.

‘‘(a) GENERAL RULE.—For purposes of section 38, in the case of an eligible small employer, the small employer health insurance credit determined under this section for any taxable year in the credit period is the amount determined under subsection (b).

‘‘(b) LIMITATION.—Subject to subsection (c), the amount determined under this subsection with respect to an eligible small employer equals the lesser of—

‘‘(1) the aggregate amount of nonelective contributions which the employer would have made during the taxable year under the arrangement if each eligible employee taken into account under paragraph (1) had enrolled in a qualified health plan which had a premium equal to the average premium (as determined by the Secretary of Health and Human Services) for the small group market in the area in which the employee enrolls for coverage.

‘‘(2) the aggregate amount of nonelective contributions which the employer would have made during the taxable year under the arrangement if each eligible employee taken into account under paragraph (1) had enrolled in a qualified health plan which had a premium equal to the average premium (as determined by the Secretary of Health and Human Services) for the small group market in the area in which the employee enrolls for coverage.

‘‘(C) PHASEOUT OF CREDIT AMOUNT BASED ON NUMBER OF EMPLOYEES.—The amount of the credit determined under subsection (b) without regard to this subsection shall be reduced (but not below zero) by the sum of the following amounts:

‘‘(1) Such amount multiplied by a fraction the numerator of which is the total number of full-time equivalent employees of the employer in excess of 10 and the denominator of which is 15.

‘‘(2) Such amount multiplied by a fraction the numerator of which is the average annual wages of the employer in excess of the dollar amount in effect under subsection (b)(1) and the denominator of which is $50,000.

‘‘(d) ELIGIBLE SMALL EMPLOYER.—For purposes of this section—

‘‘(1) IN GENERAL.—The term ‘eligible small employer’ means, with respect to any taxable year, an employer—

‘‘(A) which has no more than 25 full-time equivalent employees for the taxable year,

‘‘(B) the average annual wages of which do not exceed an amount equal to twice the dollar amount in effect under subsection (b)(1) for the taxable year, and

‘‘(C) which has in effect an arrangement described in paragraph (8).

‘‘(2) ‘‘Full-time equivalent employees’.—‘‘Full-time equivalent employees’ means, with respect to any taxable year—

‘‘(A) the total number of hours of service for which wages were paid by the employer to employees during the taxable year, by dividing—

‘‘(i) the total number of hours of service for which wages were paid by the employer to employees during the taxable year, by

‘‘(B) EXCESS HOURS NOT COUNTED.—If an eligible small employer engages in excess hours of service during any taxable year, such excess shall not be taken into account under paragraph (2).

‘‘(C) HOURS OF SERVICE.—The Secretary, in consultation with the Secretary of Labor, shall prescribe such regulations, rules, and guidance as may be necessary to determine the average number of hours of service of an employee, including rules for the application of this paragraph to employees who are not compensated on an hourly basis.

‘‘(D) AVERAGE ANNUAL WAGES.—‘‘(A) IN GENERAL.—The average annual wages of an eligible small employer for any
taxable year is the amount determined by dividing—

(i) the aggregate amount of wages which were paid by the employer to employees during the taxable year,

(ii) the number of full-time equivalent employees of the employee determined under paragraph (2) for the taxable year.

Such amount shall be rounded to the next lowest multiple of $1,000 if not otherwise such a multiple.

(B) DOLLAR AMOUNT.—For purposes of paragraph (1)(B),

(i) 2011, 2012, and 2013.—The dollar amount in effect under this paragraph for taxable years beginning in 2011, 2012, or 2013 is $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 $30,000, multiplied by the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting ‘calendar year 2012’ for ‘calendar year 1992’ in subparagraph (B) thereof.

(C) CONTRIBUTION ARRANGEMENT.—An arrangement is described in this paragraph if it requires an eligible small employer to make a nonelective contribution on behalf of each employee who enrolls in a qualified health plan offered to employees by the employer through an exchange in an amount equal to a uniform percentage (not less than 0.5 percent) of the premium cost of the qualified health plan.

(D) SEASONAL WORKER HOURS AND WAGES NOT COUNTED.—For purposes of this subsection—

(A) IN GENERAL.—The number of hours of service worked by, and wages paid to, a seasonal worker of an employer shall not be taken into account in determining the full-time equivalent employees and average annual wages of the employer unless the worker works for the employer on more than 120 days during the taxable year.

(B) DEFINITION OF SEASONAL WORKER.—The term ‘seasonal worker’ means a worker who performs labor or services on a seasonal basis as defined by the Secretary of Labor, including workers covered by section 500(b) of the Secretary of Labor, wages and tip regulations and retail workers employed exclusively during holiday seasons.

(E) OTHER RULES AND DEFINITIONS.—For purposes of this subsection—

(1) EMPLOYER.—

(A) CERTAIN EMPLOYERS EXCLUDED.—The term ‘employer’ shall not include—

(i) any employee within the meaning of section 401(c)(1),

(ii) any 2-percent shareholder (as defined in section 1372(b)) of an eligible small business which is an S corporation,

(iii) any 5-percent owner (as defined in section 416(i)(1)(B)(i)(1)) of an eligible small business, or

(iv) any individual who bears any of the relationships described in subparagraphs (A) through (G) of section 152(d)(2) to, or is a dependent described in section 152(d)(2)(H) of, an individual described in clause (1), (ii), or (iii).

(B) LEASED EMPLOYEES.—The term ‘employee’ shall include a leased employee within the meaning of section 414(h)(4).

(C) CREDIT PERIOD.—The term ‘credit period’ means, with respect to any eligible small employer, the 2-consecutive taxable year period beginning in the taxable year in which the employer (or any predecessor) offers 1 or more qualified health plans to its employees through an Exchange.

(D) CONTRIBUTION.—The term ‘nonelective contribution’ means an employer contribution other than an employer contribution pursuant to a salary reduction arrangement.

(E) WAGES.—The term ‘wages’ has the meaning given such term by section 312(a) (determined without regard to any dollar limitation contained in such section).

(F) AGGREGATION AND OTHER RULES MADE APPLICABLE.—

(A) AGGREGATION RULES.—All employers treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as a single employer for purposes of this section.

(B) OTHER RULES.—Rules similar to the rules of subsections (c), (d), and (e) of section 32 shall apply.

(C) CREDIT MADE AVAILABLE TO TAX-EXEMPT ELIGIBLE SMALL EMPLOYERS.—

(i) IN GENERAL.—In the case of a tax-exempt eligible small employer, there shall be treated as a credit allowable under subsection C (and not allowable under this subpart) the lesser of—

(A) the amount of the credit determined under this section with respect to such employer, or

(B) the amount of the payroll taxes of the employer during the calendar year in which the taxable year begins.

(2) TAX-EXEMPT ELIGIBLE SMALL EMPLOYER.—In the case of a tax-exempt eligible small employer, the term ‘tax-exempt eligible small employer’ means an eligible small employer which is an S corporation, and which is exempt from taxation under section 501(a).

(3) PAYROLL TAXES.—For purposes of this subsection—

(A) IN GENERAL.—The term ‘payroll taxes’ means—

(i) amounts required to be withheld from the wages of the tax-exempt eligible small employer, (ii) amounts required to be withheld from such employees under section 301(b), and

(iii) amounts of the taxes imposed on the tax-exempt eligible small employer under section 3111(b).

(B) SPECIAL RULE.—A rule similar to the rule of section 26(d)(2) shall apply for purposes of subparagraph (A).

(4) AGGREGATION.—

(A) AGGREGATION RULES.—All employers treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as a single employer for purposes of this section.

(B) OTHER RULES.—Rules similar to the rules of subsections (c), (d), and (e) of section 32 shall apply.

(C) CREDIT MADE AVAILABLE TO TAX-EXEMPT ELIGIBLE SMALL EMPLOYERS.—

(i) IN GENERAL.—In the case of a tax-exempt eligible small employer, there shall be treated as a credit allowable under subsection C (and not allowable under this subpart) the lesser of—

(A) the amount of the credit determined under this section with respect to such employer, or

(B) the amount of the payroll taxes of the employer during the calendar year in which the taxable year begins.

(2) TAX-EXEMPT ELIGIBLE SMALL EMPLOYER.—In the case of a tax-exempt eligible small employer, the term ‘tax-exempt eligible small employer’ means an eligible small employer which is an S corporation, and which is exempt from taxation under section 501(a).

(3) PAYROLL TAXES.—For purposes of this subsection—

(A) IN GENERAL.—The term ‘payroll taxes’ means—

(i) amounts required to be withheld from the wages of the tax-exempt eligible small employer, (ii) amounts required to be withheld from such employees under section 301(b), and

(iii) amounts of the taxes imposed on the tax-exempt eligible small employer under section 3111(b).

(B) SPECIAL RULE.—A rule similar to the rule of section 26(d)(2) shall apply for purposes of subparagraph (A).

(C) CREDIT MADE AVAILABLE TO TAX-EXEMPT ELIGIBLE SMALL EMPLOYERS.—

(i) IN GENERAL.—In the case of a tax-exempt eligible small employer, there shall be treated as a credit allowable under subsection C (and not allowable under this subpart) the lesser of—

(A) the amount of the credit determined under this section with respect to such employer, or

(B) the amount of the payroll taxes of the employer during the calendar year in which the taxable year begins.

(2) TAX-EXEMPT ELIGIBLE SMALL EMPLOYER.—In the case of a tax-exempt eligible small employer, the term ‘tax-exempt eligible small employer’ means an eligible small employer which is an S corporation, and which is exempt from taxation under section 501(a).

(3) PAYROLL TAXES.—For purposes of this subsection—

(A) IN GENERAL.—The term ‘payroll taxes’ means—

(i) amounts required to be withheld from the wages of the tax-exempt eligible small employer, (ii) amounts required to be withheld from such employees under section 301(b), and

(iii) amounts of the taxes imposed on the tax-exempt eligible small employer under section 3111(b).

(B) SPECIAL RULE.—A rule similar to the rule of section 26(d)(2) shall apply for purposes of subparagraph (A).

(4) AGGREGATION.—

(A) AGGREGATION RULES.—All employers treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as a single employer for purposes of this section.

(B) OTHER RULES.—Rules similar to the rules of subsections (c), (d), and (e) of section 32 shall apply.

(C) CREDIT MADE AVAILABLE TO TAX-EXEMPT ELIGIBLE SMALL EMPLOYERS.—

(i) IN GENERAL.—In the case of a tax-exempt eligible small employer, there shall be treated as a credit allowable under subsection C (and not allowable under this subpart) the lesser of—

(A) the amount of the credit determined under this section with respect to such employer, or

(B) the amount of the payroll taxes of the employer during the calendar year in which the taxable year begins.

(2) TAX-EXEMPT ELIGIBLE SMALL EMPLOYER.—In the case of a tax-exempt eligible small employer, the term ‘tax-exempt eligible small employer’ means an eligible small employer which is an S corporation, and which is exempt from taxation under section 501(a).

(3) PAYROLL TAXES.—For purposes of this subsection—

(A) IN GENERAL.—The term ‘payroll taxes’ means—

(i) amounts required to be withheld from the wages of the tax-exempt eligible small employer, (ii) amounts required to be withheld from such employees under section 301(b), and

(iii) amounts of the taxes imposed on the tax-exempt eligible small employer under section 3111(b).

(B) SPECIAL RULE.—A rule similar to the rule of section 26(d)(2) shall apply for purposes of subparagraph (A).

(4) AGGREGATION.—

(A) AGGREGATION RULES.—All employers treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as a single employer for purposes of this section.

(B) OTHER RULES.—Rules similar to the rules of subsections (c), (d), and (e) of section 32 shall apply.

(C) CREDIT MADE AVAILABLE TO TAX-EXEMPT ELIGIBLE SMALL EMPLOYERS.—

(i) IN GENERAL.—In the case of a tax-exempt eligible small employer, there shall be treated as a credit allowable under subsection C (and not allowable under this subpart) the lesser of—

(A) the amount of the credit determined under this section with respect to such employer, or

(B) the amount of the payroll taxes of the employer during the calendar year in which the taxable year begins.

(2) TAX-EXEMPT ELIGIBLE SMALL EMPLOYER.—In the case of a tax-exempt eligible small employer, the term ‘tax-exempt eligible small employer’ means an eligible small employer which is an S corporation, and which is exempt from taxation under section 501(a).

(3) PAYROLL TAXES.—For purposes of this subsection—

(A) IN GENERAL.—The term ‘payroll taxes’ means—

(i) amounts required to be withheld from the wages of the tax-exempt eligible small employer, (ii) amounts required to be withheld from such employees under section 301(b), and

(iii) amounts of the taxes imposed on the tax-exempt eligible small employer under section 3111(b).

(B) SPECIAL RULE.—A rule similar to the rule of section 26(d)(2) shall apply for purposes of subparagraph (A).

(4) AGGREGATION.—

(A) AGGREGATION RULES.—All employers treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as a single employer for purposes of this section.

(B) OTHER RULES.—Rules similar to the rules of subsections (c), (d), and (e) of section 32 shall apply.
Subtitle F—Shared Responsibility for Health Care

PART I—INDIVIDUAL RESPONSIBILITY

SEC. 1501. REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.

(a) FINDINGS—Congress makes the following findings:

(1) IN GENERAL.—The individual responsibility requirement provided for in this section (referred to as the "requirement") is commercial and economic in nature, and substantially affects interstate commerce, as a result of the effects described in paragraph (2).

(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.

(B) Health insurance and health care services are a significant part of the national economy. National health spending is projected to increase from $2,900,000,000,000 in 2010 to $3,100,000,000,000 in 2013. Private health insurance spending is projected to increase from $784,000,000,000 in 2010 to $854,000,000,000 in 2013 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. According to the Congressional Budget Office, the requirement will increase the number and share of Americans who are insured.

(D) The requirement achieves near-universal coverage by building upon and strengthening the private employer-based health insurance system, which covers 170,000,000 Americans nationwide. In Massachusetts, a similar requirement has strengthened private employer-based coverage, while at the same time the number of workers offered employer-based coverage has actually increased.

(E) Half of all personal bankruptcies are caused by medical expenses. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will improve financial security for families.

(F) Under the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.), the Public Health Service Act (42 U.S.C. 701 et seq.), and this Act, the Federal Government has a significant role in regulating health insurance which is in interstate commerce.

(G) Under sections 2704 and 2705 of the Public Health Service Act (as added by section 1291 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 adverse selection and reduce the health insurance risk pool to include healthy individuals, which will lower health insurance premiums. The requirement is essential to creating effective health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions.

(H) 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 scale, the requirement, together with the other provisions of this Act, will significantly reduce administrative costs and lower health insurance premiums. The requirement is essential to creating effective health insurance markets that do not require underwriting and eliminate its associated administrative costs.

(3) SUPREME COURT RULING.—In United States v. South-Eastern Underwriters Association (322 U.S. 333 (1941)), the Supreme Court held that federal health insurance is interstate commerce subject to Federal regulation.

(b) IN GENERAL.—Subtitle D of the Internal Revenue Code of 1986 is amended by adding at the end the following new chapter:

"CHAPTER 48—MAINTENANCE OF MINIMUM ESSENTIAL COVERAGE"

"Sec. 5000A. Requirement to maintain minimum essential coverage.

"Sec. 5000A. REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.

(a) REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.—An applicable individual shall for each month after 2013 ensure that the individual, and any dependent of the individual who is an applicable individual, has minimum essential coverage for such month.

(1) SHARED RESPONSIBILITY PAYMENT.—

(A) IN GENERAL.—An applicable individual who fails to meet the requirement of subsection (a) for 1 or more months during any calendar year beginning after 2013 shall be subject to a requirement penalty for such month which includes such month.

(B) PAYMENT.—Any penalty imposed by this section with respect to any month shall be included with a taxpayer's return under chapter 1 for the taxable year which includes such month.

(2) PENALTY.—If an applicable individual with respect to whom a penalty is imposed by this section for any month shall be liable for such penalty.

(3) AMOUNT OF PENALTY.—

(A) IN GENERAL.—The penalty determined under this subsection for any month with respect to any applicable individual is an amount equal to 1/12 of the applicable dollar amount for the calendar year which includes such month.

(B) DOLLAR LIMITATION.—The amount of any deduction allowed under paragraph (1), (3), (4), or (5) of section 66 of this chapter shall be rounded to the next lowest multiple of $50.

(4) MODIFIED GROSS INCOME.—The term 'modified gross income' means gross income—

(A) decreased by the amount of any deduction allowable under paragraph (1), (3), (4), or (5) of section 66(a),

(B) increased by the amount of interest received or accrued during the taxable year which is exempt from tax imposed by this chapter, and

(C) determined without regard to sections 911, 931, and 933.

(c) APPLICABLE INDIVIDUAL.—For purposes of this section—

(1) IN GENERAL.—The term 'applicable individual' means any individual who is an applicable individual as defined in paragraph (2), (3), or (4).

(2) RELIGIOUS CONSCIENCE EXEMPTION.—

(A) IN GENERAL.—The term 'applicable individual' shall not include an individual who is a member of a recognized religious sect or division as defined in paragraph (2), (3), or (4).

(B) RELIGIOUS EXEMPTIONS.—

(A) RELIGIOUS CONSCIENCE EXEMPTION.—Such term shall not include an individual for any month if such individual has in effect an exemption under section 301 of the Patient Protection and Affordable Care Act (42 U.S.C. 18011) with respect to such month.

(B) HEALTH CARE SHARING MINISTRY.—

(A) IN GENERAL.—Such term shall not include an individual for any month if such individual is a member of a health care sharing ministry for the month.
be made by reference to the affordability of the coverage to the employee.

4. INDEXING.—In the case of plan years beginning in any calendar year after 2014, the term ‘eligible employer-sponsored plan’ means, with respect to any employee, a group health plan or group health insurance coverage offered by an employer to the employee which is:

(A) a governmental plan (within the meaning of section 2791(d)(8) of the Public Health Service Act), or

(B) any other plan or coverage offered in the small or large group market within a State.

Such term shall include a grandfathered health plan, but shall not include health insurance coverage which consists of coverage of excepted benefits.

5. EXCEPTED BENEFITS NOT TREATED AS MINIMUM ESSENTIAL COVERAGE.—The term ‘minimum essential coverage’ shall not include health insurance coverage which consists of coverage of excepted benefits.

6. ENSURE PENALTY FOR FAILURE TO FILE RETURN.—In any case where the Secretary determines that a taxpayer has failed to file a return, the penalty provided by section 5017(a) of the Patient Protection and Affordable Care Act shall have the same meaning and shall be used in such title I of the Patient Protection and Affordable Care Act as determined under section 5071(a)(3) for such month.

6. ADMINISTRATION AND PROCEDURE.—

7. SPECIAL RULES.—Notwithstanding any other provision of law, the Secretary—

(A) may waive criminal prosecution for any act or omission occurring after December 31, 2013.

7. COVERAGE.

8. EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2013.

SEC. 1562. REPORTING OF HEALTH INSURANCE COVERAGE.

(a) IN GENERAL.—Part III of subchapter A of chapter 61 of the Internal Revenue Code of 1986 is amended by inserting after subpart C the following new subpart:
"Sec. 6055. Reporting of health insurance coverage."

"(a) In General.—Every person who provides minimum essential coverage to an individual during a calendar year shall, at such time as the Secretary may prescribe, make a return described in subsection (b)."

"(b) Form and Manner of Return.—"

"(1) In General.—A return is described in this subsection if—"

"(A) the name, address, and TIN of the individual whose name and TIN are required to be included on the return, and the number of the information contact for such individual, and"n

"(ii) the dates during which such individual was covered under minimum essential coverage during the calendar year,"

"(ii) the name, address, and employer identification number of the employer maintaining the plan, and"

"(C) if the health insurance coverage is a qualified health plan offered through an Exchange established under this Act, the following:

"(i) the name and address of the person receiving minimum essential coverage from the plan during the calendar year, and"

"(2) Effective Date.—The amendments made by section 1512 of the Patient Protection and Affordable Care Act are effective for any calendar year beginning on or after January 1, 2013.

"Sec. 1511. Automatic Enrollment for Employees."

The amendments made by section 1511 of the Patient Protection and Affordable Care Act are effective for the first plan year beginning on or after January 1, 2014.

"Sec. 1512. Employer Requirement to Inform Employees of Coverage Options."

The amendments made by section 1512 of the Patient Protection and Affordable Care Act are effective for the first plan year beginning on or after January 1, 2014.
"(1) In general.—If—

(a) an applicable large employer offers to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan (as defined in section 5000A(f)(1)),

(b) 1 or more full-time employees of the applicable large employer has been certified by the employer under section 1401 of the Patient Protection and Affordable Care Act as having enrolled for such month in a qualified health plan with respect to which an applicable premium tax credit or cost-sharing reduction is allowed or paid with respect to the employee,

then there is hereby imposed on the employer an assessable payment equal to the product of the number of full-time employees of the applicable large employer described in subparagraph (B) for such month and 400 percent of the applicable payment amount.

(2) Overall limitation.—The aggregate amount of tax determined under paragraph (1) with respect to all employees of an applicable large employer during the calendar year, and

the product of the applicable payment amount and the number of individuals employed by the employer as full-time employees during such month.

(d) Definitions and special rules.—For purposes of this section—

(1) APPLICABLE PAYMENT AMOUNT.—The term 'applicable payment amount' means, with respect to any month, 1⁄12 of $750.

(2) APPLICABLE LARGE EMPLOYER.—

(A) in general.—The term 'applicable large employer' means, with respect to a calendar year, an employer who employed an average of at least 50 full-time employees on business days during the preceding calendar year.

(B) EXEMPTION FOR CERTAIN EMPLOYERS.—

(i) in general.—An employer shall not be considered to employ more than 50 full-time employees if—

(ii) the employer's workforce exceeds 50 full-time employees for 120 days or fewer during the calendar year, and

(iii) in excess of 50 employed during such 120-day period were seasonal workers.

(ii) Definition of seasonal workers.—The term 'seasonal worker' means a worker who performs labor or services on a seasonal basis as defined by the Secretary of Labor, including workers covered by section 502(b)(1) of the Employee Retirement Income Security Act of 1974.

(c) Rules for determining employer size.—For purposes of this paragraph—

(i) application of aggregation rule for employers.—All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as 1 employer.

(ii) employers not in existence in preceding year.—In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is an applicable large employer shall be based on the average number of its full-time employees during each of the 3 calendar years preceding the calendar year in which it is reasonably expected such employer will employ on business days in the current calendar year.

(iii) Predecessors.—Any reference in this subparagraph to any predecessor of such employer.
"(d) **COORDINATION WITH OTHER REQUIREMENTS.—**To the maximum extent feasible, the Secretary may provide that—

(1) any return or statement required to be provided for purposes of this section may be provided as part of any return or statement required under section 6051 or 6055, and

(2) in the case of an applicable large employer which is a governmental unit or any agency or instrumentality thereof, the person appropriately designated for purposes of this section shall make the returns and statements required by this section.

(f) **DEFINITIONS.—**For purposes of this section, any term used in this section which is also used in section 4980H shall have the meaning given such term by section 4980H."

(a) **ASSIGNABLE PENALTIES.—**

(1) Subparagraph (d) of section 6724(d)(1) of the Internal Revenue Code of 1986 (relating to definitions, as amended by section 1502, is amended by striking "or" at the end of clause (xxi) and at the end of clause (xxvi) and inserting "or", and by inserting after clause (xxv) the following new clause:

"(xxv) section 6056 (relating to returns and statements required by this section)."

(2) Paragraph (2) of section 6724(d) of such Code (as amended, is amended by striking "or" at the end of subparagraph (FF), by striking the period at the end of subparagraph (GG) and inserting "or", and by inserting after such subparagraph (GG) the following new subparagraph:

"(GG) section 6056 (relating to returns and statements required by this section)."

(b) **CONFORMING AMENDMENTS.—**Subsection (a) of section 6055 (relating to disclosures, is amended by striking "or" at the end of clause (ii) and inserting "or", and by inserting after clause (ii) the following:

"(ii) section 6056 (relating to returns and statements required by this section)."

(c) **CONFORMING AMENDMENT.—**The table of sections for part D of part III of subchapter A of chapter 61 of such Code, as added by section 1502, is amended by adding at the end of the following new item:

"Sec. 6056. Large employers required to report on health insurance coverage."
SEC. 18C. PROTECTIONS FOR EMPLOYEES.

"(a) PROHIBITION.—No employer shall discharge or in any manner discriminate against any employee with respect to his or her compensation, terms, conditions, or other privileges of employment because the employee (or an individual acting on the request of the employee) has

(1) under section 36B of the Internal Revenue Code of 1986 or a subsidy under section 1402 of this Act;

(2) provided, caused to be provided, or is about to provide or cause to be provided, by the employer, the Federal Government, or the attorney general of a State information relating to any violation of, or any act or omission reasonably believed to be a violation of, any provision of this title (or an amendment made by this title);

(3) testified or is about to testify in a proceeding concerning such violation;

(4) assisted or participated, or is about to assist or participate, in such a proceeding;

(5) objected to, or refused to participate in, any activity, policy, practice, or assigned task that the employee (or another person reasonably believed to be in violation of any provision of this title (or amendment), or any regulation, standard, or order, or under this title (or amendment).

"(b) COMPLAINT PROCEDURE.—

(1) In general.—

(A) In general, an employee who believes that he or she has been discharged or otherwise discriminated against by any employer in violation of this section may seek relief in accordance with the procedures, notification, burdens of proof, remedies, and statutes of limitation set forth in section 208(b) of title 15, United States Code.

(B) In general.—Nothing in this section shall be deemed to diminish the rights, privileges, or remedies of any employee under any Federal or State law or under any bargaining agreement. The rights and remedies in this section may not be waived by any agreement, policy, form, or condition of employment.

SEC. 1559. OVERSIGHT.

The Inspector General of the Department of Health and Human Services shall have oversight authority with respect to the administration and implementation of this title and subsection.

SEC. 1560. RULES OF CONSTRUCTION.

(a) No Effect on Antitrust Laws.—Nothing in this title (or an amendment made by this title) shall be construed to modify or limit the application of the exemption for Hawaii's title (or an amendment made by this title) shall be construed to modify or limit any existing Federal requirement concerning the State agency responsible for determining eligibility for programs identified in section 1413.

SEC. 1561. HEALTH INFORMATION TECHNOLOGY ENROLLMENT STANDARDS AND PROTOCOLS.

Title XXX of the Public Health Service Act (42 U.S.C. 300gg et seq.) is amended by adding at the end the following:

"SEC. 2101. HEALTH INFORMATION TECHNOLOGY ENROLLMENT STANDARDS AND PROTOCOLS.

"(a) IN GENERAL.—

(1) STANDARDS AND PROTOCOLS.—Not later than 180 days after the date of enactment of this title, the Secretary, in consultation with the HIT Policy Committee and the HIT Standards Committee, shall develop interoperable and secure standards and protocols that facilitate enrollment of individuals in Federal and State health and human services programs, as determined by the Secretary.

(2) METHODS.—The Secretary shall facilitate enrollment in such programs through methods determined appropriate by the Secretary, which may include providing individuals and third parties authorized by such individuals and their designees notification of eligibility and verification of eligibility required under this section.

(b) CONTENT.—The standards and protocols for electronic enrollment in the Federal and State programs described in subsection (a) shall allow for the following:

(1) Electronic matching against existing Federal and State data, including vital records, enrollment systems, tax records, and other data determined appropriate by the Secretary to serve as evidence of eligibility and in lieu of paper-based documentation.

(2) Simplification and submission of electronic documentation, digitization of documents, and systems verification of eligibility.

(3) Reuse of stored eligibility information (including documentation) to assist with retention of eligible individuals.

(4) Capability for individuals to apply, re-certify and manage their eligibility information online, including at home, at points of service, and other community-based locations.

(5) Ability to expand the enrollment system to integrate new programs, rules, and conditions of service, and other community-based locations.

(6) Notification of eligibility, recertification, and other needed communication regarding eligibility, which may include communication via email and cellular phones.

(7) Other functionalities necessary to provide eligibles with streamlined enrollment process.

(c) APPROVAL AND NOTIFICATION.—With respect to any standard or protocol developed under paragraph (1), the Secretary shall determine what entities are qualified to receive enrollment HIT under subparagraph (B) at no cost.

(d) QUALIFIED ENTITIES.—The Secretary shall ensure that appropriate enrollment HIT technology in accordance with paragraph (4) and (iii) other such information as the Secretary may require.

(8) SHARING.—

(A) IN GENERAL.—The Secretary shall ensure that appropriate enrollment HIT technology in accordance with paragraph (4) and (iii) other such information as the Secretary may require.

(9) APPLICABILITY.—Section 2735 of the Public Health Service Act (42 U.S.C. 300gg-21) as redesignated by section 1001(d), is amended—

(1) by striking subsection (a);

(2) in subsection (b),—

(A) in paragraph (1), by striking "1 through 3" and inserting "1 and 2";

(B) in paragraph (2),—

(i) in subparagraph (A), by striking "subparagraph (E)" and inserting "subparagraph (D) or (E)";

(ii) by striking "1 through 3" and inserting "1 and 2";

(3) in subsection (c), by striking "1 through 3 shall not apply to any group" and inserting "1 and 2 shall not apply to any individual coverage or any group";

(4) in subsection—

(A) in paragraph (1), by striking "1 through 3 shall not apply to any group" and inserting "1 and 2 shall not apply to any individual coverage or any group";

(B) in paragraph (2),—

(i) in the matter preceding subparagraph (A), by striking "1 through 3 shall not apply to any group" and inserting "1 and 2 shall not apply to any individual coverage or any group";

(ii) in subparagraph (C), by inserting "or, with respect to individual coverage, under any health insurance coverage maintained by the same health insurance issuer"; and

(C) in paragraph (3), by striking "1 through 3 shall not apply to any individual coverage or any group";

SEC. 1562. CONFORMING AMENDMENTS.

(a) APPLICABILITY.—Section 2735 of the Public Health Service Act (42 U.S.C. 300gg-21) as redesignated by section 1001(d), is amended—

(1) by striking subsection (a);

(2) in subsection (b),—

(A) in paragraph (1), by striking "1 through 3" and inserting "1 and 2";

(B) in paragraph (2),—

(i) in subparagraph (A), by striking "subparagraph (E)" and inserting "subparagraph (D) or (E)";

(ii) by striking "1 through 3" and inserting "1 and 2";

(iii) by adding at the end the following:

(9) ELECTION NOT APPLICABLE.—The election described in subparagraph (A) shall not be available with respect to the provisions of such paragraph;

(2) in subsection (c), by striking "1 through 3 shall not apply to any group" and inserting "1 and 2 shall not apply to any individual coverage or any group"; and

(3) in subsection (d),—

(A) in paragraph (1), by striking "1 through 3 shall not apply to any group" and inserting "1 and 2 shall not apply to any individual coverage or any group";

(B) in paragraph (2),—

(i) in the matter preceding subparagraph (A), by striking "1 through 3 shall not apply to any group" and inserting "1 and 2 shall not apply to any individual coverage or any group"; and

(ii) in subparagraph (C), by inserting "or, with respect to individual coverage, under any health insurance coverage maintained by the same health insurance issuer"; and

(C) in paragraph (3), by striking "1 through 3 shall not apply to any individual coverage or any group";

(b) DEFINITIONS.—Section 2791(d) of the Public Health Service Act (42 U.S.C. 300gg-91(d) is amended by adding at the end the following:

"(1) The Secretary shall award grant to eligible entities to develop new, and adapt existing, technology systems to implement the HIT enrollment standards and protocols developed under subsection (a) (referred to in this subsection as "appropriate HIT technology").
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‘‘(20) QUALIFIED HEALTH PLAN.—The term
‘qualified health plan’ has the meaning given
such term in section 1301(a) of the Patient
Protection and Affordable Care Act.
‘‘(21) EXCHANGE.—The term ‘Exchange’
means an American Health Benefit Exchange
established under section 1311 of the Patient
Protection and Affordable Care Act.’’.
(c) TECHNICAL AND CONFORMING AMENDMENTS.—Title XXVII of the Public Health
Service Act (42 U.S.C. 300gg et seq.) is
amended—
(1) in section 2704 (42 U.S.C. 300gg), as so redesignated by section 1201(2)—
(A) in subsection (c)—
(i) in paragraph (2), by striking ‘‘group
health plan’’ each place that such term appears and inserting ‘‘group or individual
health plan’’; and
(ii) in paragraph (3)—
(I) by striking ‘‘group health insurance’’
each place that such term appears and inserting ‘‘group or individual health insurance’’; and
(II) in subparagraph (D), by striking ‘‘small
or large’’ and inserting ‘‘individual or
group’’;
(B) in subsection (d), by striking ‘‘group
health insurance’’ each place that such term
appears and inserting ‘‘group or individual
health insurance’’; and
(C) in subsection (e)(1)(A), by striking
‘‘group health insurance’’ and inserting
‘‘group or individual health insurance’’;
(2) by striking the second heading for subpart 2 of part A (relating to other requirements);
(3) in section 2725 (42 U.S.C. 300gg-4), as so
redesignated by section 1001(2)—
(A) in subsection (a), by striking ‘‘health
insurance issuer offering group health insurance coverage’’ and inserting ‘‘health insurance issuer offering group or individual
health insurance coverage’’;
(B) in subsection (b)—
(i) by striking ‘‘health insurance issuer offering group health insurance coverage in
connection with a group health plan’’ in the
matter preceding paragraph (1) and inserting
‘‘health insurance issuer offering group or
individual health insurance coverage’’; and
(ii) in paragraph (1), by striking ‘‘plan’’
and inserting ‘‘plan or coverage’’;
(C) in subsection (c)—
(i) in paragraph (2), by striking ‘‘group
health insurance coverage offered by a
health insurance issuer’’ and inserting
‘‘health insurance issuer offering group or
individual health insurance coverage’’; and
(ii) in paragraph (3), by striking ‘‘issuer’’
and inserting ‘‘health insurance issuer’’; and
(D) in subsection (e), by striking ‘‘health
insurance issuer offering group health insurance coverage’’ and inserting ‘‘health insurance issuer offering group or individual
health insurance coverage’’;
(4) in section 2726 (42 U.S.C. 300gg-5), as so
redesignated by section 1001(2)—
(A) in subsection (a), by striking ‘‘(or
health insurance coverage offered in connection with such a plan)’’ each place that such
term appears and inserting ‘‘or a health insurance issuer offering group or individual
health insurance coverage’’;
(B) in subsection (b), by striking ‘‘(or
health insurance coverage offered in connection with such a plan)’’ each place that such
term appears and inserting ‘‘or a health insurance issuer offering group or individual
health insurance coverage’’; and
(C) in subsection (c)—
(i) in paragraph (1), by striking ‘‘(and
group health insurance coverage offered in
connection with a group health plan)’’ and
inserting ‘‘and a health insurance issuer offering group or individual health insurance
coverage’’;

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(ii) in paragraph (2), by striking ‘‘(or
health insurance coverage offered in connection with such a plan)’’ each place that such
term appears and inserting ‘‘or a health insurance issuer offering group or individual
health insurance coverage’’;
(5) in section 2727 (42 U.S.C. 300gg-6), as so
redesignated by section 1001(2), by striking
‘‘health insurance issuers providing health
insurance coverage in connection with group
health plans’’ and inserting ‘‘and health insurance issuers offering group or individual
health insurance coverage’’;
(6) in section 2728 (42 U.S.C. 300gg-7), as so
redesignated by section 1001(2)—
(A) in subsection (a), by striking ‘‘health
insurance coverage offered in connection
with such plan’’ and inserting ‘‘individual
health insurance coverage’’;
(B) in subsection (b)—
(i) in paragraph (1), by striking ‘‘or a
health insurance issuer that provides health
insurance coverage in connection with a
group health plan’’ and inserting ‘‘or a
health insurance issuer that offers group or
individual health insurance coverage’’;
(ii) in paragraph (2), by striking ‘‘health
insurance coverage offered in connection
with the plan’’ and inserting ‘‘individual
health insurance coverage’’; and
(iii) in paragraph (3), by striking ‘‘health
insurance coverage offered by an issuer in
connection with such plan’’ and inserting
‘‘individual health insurance coverage’’;
(C) in subsection (c), by striking ‘‘health
insurance issuer providing health insurance
coverage in connection with a group health
plan’’ and inserting ‘‘health insurance issuer
that offers group or individual health insurance coverage’’; and
(D) in subsection (e)(1), by striking ‘‘health
insurance coverage offered in connection
with such a plan’’ and inserting ‘‘individual
health insurance coverage’’;
(7) by striking the heading for subpart 3;
(8) in section 2731 (42 U.S.C. 300gg-11), as so
redesignated by section 1001(3)—
(A) by striking the section heading and all
that follows through subsection (b);
(B) in subsection (c)—
(i) in paragraph (1)—
(I) in the matter preceding subparagraph
(A), by striking ‘‘small group’’ and inserting
‘‘group and individual’’; and
(II) in subparagraph (B)—
(aa) in the matter preceding clause (i), by
inserting ‘‘and individuals’’ after ‘‘employers’’;
(bb) in clause (i), by inserting ‘‘or any additional
individuals’’
after
‘‘additional
groups’’; and
(cc) in clause (ii), by striking ‘‘without regard to the claims experience of those employers and their employees (and their dependents) or any health status-related factor
relating to such’’ and inserting ‘‘and individuals without regard to the claims experience
of those individuals, employers and their employees (and their dependents) or any health
status-related factor relating to such individuals’’; and
(ii) in paragraph (2), by striking ‘‘small
group’’ and inserting ‘‘group or individual’’;
(C) in subsection (d)—
(i) by striking ‘‘small group’’ each place
that such appears and inserting ‘‘group or individual’’; and
(ii) in paragraph (1)(B)—
(I) by striking ‘‘all employers’’ and inserting ‘‘all employers and individuals’’;
(II) by striking ‘‘those employers’’ and inserting ‘‘those individuals, employers’’; and
(III) by striking ‘‘such employees’’ and inserting ‘‘such individuals, employees’’;
(D) by striking subsection (e);
(E) by striking subsection (f); and

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(F) by transferring such section (as amended by this paragraph) to appear at the end of
section 2702 (as added by section 1001(4));
(9) in section 2732 (42 U.S.C. 300gg-12), as so
redesignated by section 1001(3)—
(A) by striking the section heading and all
that follows through subsection (a);
(B) in subsection (b)—
(i) in the matter preceding paragraph (1),
by striking ‘‘group health plan in the small
or large group market’’ and inserting
‘‘health insurance coverage offered in the
group or individual market’’;
(ii) in paragraph (1), by inserting ‘‘, or individual, as applicable,’’ after ‘‘plan sponsor’’;
(iii) in paragraph (2), by inserting ‘‘, or individual, as applicable,’’ after ‘‘plan sponsor’’; and
(iv) by striking paragraph (3) and inserting
the following:
‘‘(3) VIOLATION OF PARTICIPATION OR CONTRIBUTION RATES.—In the case of a group
health plan, the plan sponsor has failed to
comply with a material plan provision relating to employer contribution or group participation rules, pursuant to applicable State
law.’’;
(C) in subsection (c)—
(i) in paragraph (1)—
(I) in the matter preceding subparagraph
(A), by striking ‘‘group health insurance coverage offered in the small or large group
market’’ and inserting ‘‘group or individual
health insurance coverage’’;
(II) in subparagraph (A), by inserting ‘‘or
individual, as applicable,’’ after ‘‘plan sponsor’’;
(III) in subparagraph (B)—
(aa) by inserting ‘‘or individual, as applicable,’’ after ‘‘plan sponsor’’; and
(bb) by inserting ‘‘or individual health insurance coverage’’; and
(IV) in subparagraph (C), by inserting ‘‘or
individuals, as applicable,’’ after ‘‘those
sponsors’’; and
(ii) in paragraph (2)(A)—
(I) in the matter preceding clause (i), by
striking ‘‘small group market or the large
group market, or both markets,’’ and inserting ‘‘individual or group market, or all markets,’’; and
(II) in clause (i), by inserting ‘‘or individual, as applicable,’’ after ‘‘plan sponsor’’;
and
(D) by transferring such section (as amended by this paragraph) to appear at the end of
section 2703 (as added by section 1001(4));
(10) in section 2733 (42 U.S.C. 300gg-13), as
so redesignated by section 1001(4)—
(A) in subsection (a)—
(i) in the matter preceding paragraph (1),
by striking ‘‘small employer’’ and inserting
‘‘small employer or an individual’’;
(ii) in paragraph (1), by inserting ‘‘, or individual, as applicable,’’ after ‘‘employer’’
each place that such appears; and
(iii) in paragraph (2), by striking ‘‘small
employer’’ and inserting ‘‘employer, or individual, as applicable,’’;
(B) in subsection (b)—
(i) in paragraph (1)—
(I) in the matter preceding subparagraph
(A), by striking ‘‘small employer’’ and inserting ‘‘employer, or individual, as applicable,’’;
(II) in subparagraph (A), by adding ‘‘and’’
at the end;
(III) by striking subparagraphs (B) and (C);
and
(IV) in subparagraph (D)—
(aa) by inserting ‘‘, or individual, as applicable,’’ after ‘‘employer’’; and
(bb) by redesignating such subparagraph as
subparagraph (B);
(ii) in paragraph (2)—
(I) by striking ‘‘small employers’’ each
place that such term appears and inserting

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SEC. 715. ADDITIONAL MARKET REFORMS.

(a) GENERAL RULE.—Except as provided in subsection (b), (2)

(1) the provisions of part A of title XXVII of the Public Health Service Act (as amended by the Patient Protection and Affordable Care Act) shall apply to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans, as if included in this subpart; and

(2) to the extent that any provision of this part conflicts with a provision of such part A with respect to group health plans, or health insurance issuers providing health insurance coverage in connection with group health plans, the provisions of such part A shall apply.

(b) EXCEPTION.—Notwithstanding subsection (a), the provisions of sections 2716 through 2718 of title XXVII of the Public Health Service Act (as amended by the Patient Protection and Affordable Care Act) shall not apply with respect to self-insured group health plans, and the provisions of this part shall continue to apply to such plans as if such sections of the Public Health Service Act (as so amended) had not been enacted.

(1) TECHNICAL AMENDMENT TO THE INTERNAL REVENUE CODE OF 1986.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended by adding at the end the following:

SEC. 9815. ADDITIONAL MARKET REFORMS.

(a) GENERAL RULE.—Except as provided in subsection (b), (1)

(1) the provisions of part A of title XXVII of the Public Health Service Act (as amended by the Patient Protection and Affordable Care Act) shall apply to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans, the provisions of such part A shall apply.

(b) EXCEPTION.—Notwithstanding subsection (a), the provisions of sections 2716 through 2718 of title XXVII of the Public Health Service Act (as amended by the Patient Protection and Affordable Care Act) shall not apply with respect to self-insured group health plans, and the provisions of this part shall continue to apply to such plans as if such sections of the Public Health Service Act (as so amended) had not been enacted.

(2) to the extent that any provision of this subchapter conflicts with a provision of such part A with respect to group health plans, or health insurance issuers providing health insurance coverage in connection with group health plans, the provisions of such part A shall apply.

(3) The Federal Government may, in its discretion, no later than December 31, 2018, promulgate such regulations as may be necessary to carry into effect the provisions of this section.

(4) Nothing in this section shall be construed to apply to group health plans that are subject to section 2719(b)(1).

(5) This section shall not apply to any group health plan that is subject to section 2719(b)(1) and that is not a group health plan under such section.

TITLE II—ROLE OF PUBLIC PROGRAMS

Subtitle A—Improved Access to Medicaid

SEC. 201. MEDICAL COVERAGE FOR THE LOW-EST INCOME POPULATIONS.

(a) COVERAGE FOR INDIVIDUALS WITH INCOME AT OR BELOW 133 PERCENT OF THE POVERTY LINE.—(1) BEGINNING 2014.—Section 1902(a)(10)(A)(i) of the Social Security Act (42 U.S.C. 1396a) is amended—

(A) by striking in paragraph (24), by striking “or” at the end of the following:

(2) in section 1711(e)(2)(B) any provision of the Patient Protection and Affordable Care Act, nothing in such Act (or an amendment made by such Act) shall be construed to— (1) prohibit (or authorize the Secretary of Health and Human Services to promulgate regulations that prohibit) a group health plan or health insurance issuer from carrying out utilization management techniques that are commonly used as of the date of enactment of this Act; or

(2) change the application of the amendments made by this subtitle.

(b) TECHNICAL AMENDMENT TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.—(1) except as provided in part 7 of this subpart—A part of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1181 et seq.) is amended, by adding at the end the following:

SEC. 102. المتعلقة בפועלי הפרטים במגזר הציבורי

(1) The medical assistance provided to an individual described in clause (ii) of paragraph (1) shall not apply with respect to a plan that is subject to section 1317(b)(1) or benchmark equivalent coverage described in section 1317(b)(2). Such medical assistance shall be provided subject to the requirements of section 1317(b)(3) with regard to whether a State otherwise has elected the option to provide medical assistance through coverage under that section, unless an individual described in clause (ii) of paragraph (1) is also an individual for whom, under subparagraph (B) of section 1315(a)(2), the State may not require enrollment in benchmark coverage described in section 1317(b)(1) or benchmark equivalent coverage described in section 1317(b)(2).

(2) Federal Funding For Cost Of Covering Newly Eligible Individuals.—Section 1905 of the Social Security Act (42 U.S.C. 1396d), is amended—

(A) in subsection (b), in the first sentence, by inserting “subsection (y) and” before “section 1933(d)”; and

(B) by adding at the end the following:

(3) INCREASED FMAP FOR MEDICAL ASSISTANCE FOR NEWLY ELIGIBLE MANDATORY INDIVIDUALS.—(1) AMOUNT OF INCREASE.—(A) 100 PERCENT FMAP.—During the period that begins on January 1, 2014, and ends on December 31, 2015, notwithstanding subsection (b), the Federal medical assistance percentage determined for a State that is one of the 50 States or the District of Columbia for each fiscal year occurring during that period with respect to amounts expended for medical assistance for newly eligible individuals described in subsection (v) of section 1902(a)(10)(A)(i) shall be equal to 100 percent.

(B) 2017 AND 2018.—(i) For the fiscal year beginning January 1, 2017, and the fiscal year beginning January 1, 2018, the Federal medical assistance percentage determined for a State that is one of the 50 States or the District of Columbia for each fiscal year occurring during that period with respect to amounts expended for medical assistance for newly eligible individuals described in subsection (v) of section 1902(a)(10)(A)(i) shall be equal to 100 percent.

(2) APPLICABLE PERCENTAGE POINT INCREASE.—(A) IN GENERAL.—For purposes of clause (i), the applicable percentage point increase for a quarter is the following:
“(D) EXPANSION STATE DEFINED.—For purposes of the table in subclause (I), a State is an expansion State if, on the date of the enactment of the Patient Protection and Affordable Care Act, the State offers health benefits coverage statewide to parents and nonpregnant, childless adults whose income is at or below 133 percent of the poverty line, that is not dependent on access to employer coverage, employer contribution, or employment and is not limited to premium assistance, hospital-only benefits, a high deductible health plan, or alternative benefits under a demonstration program authorized under section 1906. A State that offers health benefits coverage to only parents or only nonpregnant childless adults described in the preceding sentence shall not be considered an expansion State.

“(C) 2019 AND SUBSEQUENT YEARS.—Beginning January 1, 2019, notwithstanding subsection (D), the Federal medical assistance percentage determined for a State that is one of the 50 States or the District of Columbia for each fiscal year quarter occurring during that period with respect to amounts expended for medical assistance for newly eligible individuals described in subclause (VIII) of section 1902(a)(10)(A)(i), shall be increased by 32.3 percentage points.

“(D) LIMITATION.—The Federal medical assistance percentage determined for a State under subparagraph (B) or (C) shall in no case be more than 95 percent.

“(2) DEFINITIONS.—In this subsection:

“(A) NEWLY ELIGIBLE.—The term ‘newly eligible,’ with respect to an individual described in subclause (VIII) of section 1902(a)(10)(A)(i), an individual who is not under 19 years of age (or such higher age as the State may have elected) and who, on the date the Patient Protection and Affordable Care Act, is not eligible under the State plan or under a waiver of the plan for full benefits or for benchmark coverage described in subparagraph (A), (B), or (C) of section 1901(b)(1) or benchmark equivalent coverage described in section 1937(b)(2) that has an aggregate actuarial value that is at least actuarially equivalent to benchmark coverage described in subparagraph (A), (B), or (C) of section 1901(b)(1), or is eligible but not enrolled (or is on a waiting list) for such benefit or coverage through a waiver under the plan that has a capped or limited enrollment that is full.

“(B) FULL BENEFITS.—The term ‘full benefits,’ with respect to an individual, medical assistance for all services covered under the State plan under this title that is not less in amount, duration, or scope, or is determined by the Secretary to be substantially equivalent, to the medical assistance available for an individual described in section 1902(a)(10)(A)(i).

“(C) STATES TO OFFER COVERAGE EARLIER AND PRESumptIVE ELIGIBILITY: CHILDREN REQUIRED TO HAVE COVERAGE FOR PARENTS TO BE ELIGIBLE.—

“(1) IN GENERAL.—Subsection (k) of section 1902 of the Social Security Act (as added by paragraph (2)), is amended by inserting after paragraph (1) the following:

“(2) The first day of any fiscal year quarter that begins on or after January 1, 2011, and before January 1, 2014, a State may elect through a State plan amendment to provide medical assistance to individuals who would be described in subclause (VIII) of section 1902(a)(10)(A)(i) if that subclause were effective before January 1, 2014. A State may elect to phase-in the extension of eligibility for medical assistance to such individuals based on income, so long as the State does not extend such eligibility to individuals described in such subclause with higher income described in such subclause with lower income eligible for medical assistance.

“(3) If an individual in subclause (VIII) of section 1902(a)(10)(A)(i) is the parent of a child who is under 19 years of age (or such higher age as the State may have elected) who is newly eligible under the State plan unless the individual’s child is enrolled under the State plan or under a waiver of the plan or is enrolled in other health insurance coverage. For purposes of the preceding sentence, the term ‘parent’ includes an individual treated as a caretaker relative for purposes of carrying out section 1911.

“(B) PRESUMPTIVE ELIGIBILITY.—Section 1905 of the Social Security Act (42 U.S.C. 1396b–1) is amended by adding at the end the following:

“(1) If the State has elected the option to provide a presumptive eligibility period under this section or section 1920A, the State may elect to provide a presumptive eligibility period (as defined in subsection (b)(1)) for individuals who are newly eligible for medical assistance described in such subclause with lower income eligible for medical assistance, in the same manner as the State provides for such a period under this section or section 1920A, subject to such guidance as the Secretary shall establish.

“(5) CONFORMING AMENDMENTS.—

“(A) Section 1902(a)(10) of such Act (42 U.S.C. 1396a(a)(10)) is amended—

“(i) by inserting ‘‘and (ii)’’ after ‘‘(i)’’;

“(ii) by striking ‘‘and (ii)’’ after ‘‘(i)’’;

“(iii) by striking ‘‘and (iii)’’ after ‘‘(i)’’;

“(iv) by inserting ‘‘and (iv)’’ after ‘‘(i)’’;

“(B) Section 1906(a) of such Act (42 U.S.C. 1396(a)) is amended—

“(1) by striking ‘‘or’’ at the end of clause (xiii); and

“(2) by inserting ‘‘or’’ at the end of clause (xiii).

“(C) Section 1905(a) of such Act (42 U.S.C. 1396b) is amended—

“(1) by striking ‘‘and’’ at the end of clause (xiii); and

“(2) by inserting ‘‘or’’ at the end of clause (xiii).

“(3) by inserting ‘‘or’’ at the end of clause (xiii).

“(4) by inserting ‘‘or’’ at the end of clause (xiii).

“(b) MAINTENANCE OF MEDICAID INCOME ELIGIBILITY.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

“(1) in section (a)(10) (A) (i) (VIII), by striking ‘‘and’’ at the end of paragraph (72); and

“(2) in section (a)(10) (A) (i) (VIII), by striking the period at the end of paragraph (73) and inserting ‘‘and’’;

“(3) by inserting after paragraph (73) the following new paragraph:

“(74) provide for maintenance of effort under the State plan or under any waiver of the plan in accordance with subsection (gg); and

“(4) by inserting at the end the following new subsection:

“(gg) MAINTENANCE OF EFFORT.—

“(1) GENERAL REQUIREMENT TO MAINTAIN ELIGIBILITY STANDARDS.—

“(A) Section 1311 of the Patient Protection and Affordable Care Act and ends on the date on which the Secretary determines that an exchange has established a budget deficit or, with respect to a State that is one of the 50 States or the District of Columbia for each calendar quarter occurring during such period, a State shall not have in effect eligibility standards, methodologies, or procedures under the State plan or under any waiver of such plan that is in effect during that period, that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under the plan or waiver that are in effect on the date of enactment of the Patient Protection and Affordable Care Act.

“(B) CHANGE OF ELIGIBILITY STANDARDS FOR CHILDREN UNTIL OCTOBER 1, 2019.—The requirement under paragraph (1) shall cease to apply to a State with respect to nonpregnant, nondisabled adults who are eligible for medical assistance under the State plan or under a waiver of the plan at the option of the State and whose income exceeds 133 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size described in on or after December 31, 2013, the Secretary certifies to the Secretary that, with respect to the State fiscal year during which the certification is made, the State has an average deficit, or with respect to the succeeding State fiscal year, the State is projected to have a budget deficit. Upon submission of such a certification by the Secretary, the requirement under paragraph (1) shall not apply to the State with respect to any remaining portion of the period described in the preceding sentence.

“(C) TRANSITION PERIOD FOR CHILDREN.—

“(1) STATES SHALL APPLY MODIFIED GROSS INCOME.—A State’s determination of income for fiscal year quarter that begins on or after January 1, 2017, and before January 1, 2018, for paragraph (1) shall not apply to the State with respect to any remaining portion of the period described in the preceding sentence.
in accordance with subsection (e)(14) shall not be considered to be eligibility standards, methodologies, or procedures that are more restrictive than the standards, methodologies, or procedures in effect under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act for purposes of determining compliance with the requirements of paragraph (1), (2), or (3).

**"(B) STATES MAY EXPAND ELIGIBILITY OR MOVE WAVERED POPULATIONS INTO COVERAGE UNDER MEDICAID"**

A State that applies eligibility standards, methodologies, or procedures in effect under the State plan under this title, except as provided in subparagraph (D), shall not be considered to have in effect eligibility standards, methodologies, or procedures in effect under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act, or that makes individuals who, on such date of enactment, are eligible for medical assistance under a waiver of the State plan, by striking "and" at the end of paragraph (73); increased by 10 percent.

**"(3)''**

**"(B) DEEMED COMPLIANCE.—Coverage provided with respect to an individual described in paragraph (2) that is offered by an entity under the State plan under section 1902(a)(10)(A) of the services described in section 1905(a)(4)(B) (relating to early and periodic screening, diagnostic, and treatment services defined in section 1905(r) and provided in accordance with section 1902(a)(4), shall be deemed to satisfy the requirements of subparagraph (A) and (B) of this subsection, except as provided in section 1906(f).''**

**"(4)''**

**"(C) ANNUAL REPORTS ON MEDICAID ENROLLMENT.—**

1. **"(1) STATE REPORTS.—** Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by subsection (b), is amended—

2. **"(A) by striking "and" at the end of paragraph (74); and**

3. **"(B) by striking the period at the end of paragraph (74) and inserting ";"; and**

4. **"(C) by inserting after paragraph (74) the following new paragraph:**

5. **"(75) provide that, beginning January 2015, and annually thereafter, the State shall submit a report to the Secretary that contains—"**

6. **"(A) the total number of enrolled and newly enrolled individuals in the State plan or under a waiver of the plan for the fiscal year ending on September 30 of the preceding calendar year for the State population, including children, parents, nonpregnant childless adults, disabled individuals, elderly individuals, and such other categories or subgroups of the population as the Secretary determines appropriate.

7. **"(B) a description, which may be specified in the following manner, of which may be specified by population, the outreach and enrollment processes used by the State during such fiscal year; and**

8. **"(C) any other data determined necessary by the Secretary to monitor enrollment and retention of individuals eligible for medical assistance under the State plan or under a waiver of the plan as the Secretary may require."**

9. **"(D) An individual described in section 1902(a)(10)(A)(ii)(XX),'' after "coverage to individuals described in subclause (XX) of subsection (a)(10)(A)(ii) based on the categorical group (including nonpregnant childless adults) or income, so long as the State does not also determine that enrollment to indi-**

10. **"(2)''**

11. **"(B) by inserting "or" at the end of clause (xvi); and**

12. **"(C) by inserting after clause (xvi) the following:**

13. **"(xv) individuals described in section 1902(a)(10)(A)(ii)(XX),'' after "individuals described in such subclause with lower income that are not less than the Federal poverty level, the individual is required, including with respect to the imposition of premiums and cost-sharing, a State shall use the modified gross income of an individual and, in the case of an individual in a family greater than one, the household income of such family. A State shall establish income eligibility thresholds for populations to be eligible for medical assistance under the State plan or under any waiver of such plan for any other purpose applicable under the plan or waives for which a determination of income is not required, including with respect to the imposition of premiums and cost-sharing, a State shall use the modified gross income of an individual and, in the case of an individual in a family greater than one, the household income of such family. A State shall establish income eligibility thresholds for populations to be eligible for medical assistance under the State plan or under any waiver of such plan for any other purpose applicable under the plan or waives for which a determination of income is not required, including with respect to the imposition of premiums and cost-sharing, a State shall use the modified gross income of an individual and, in the case of an individual in a family greater than one, the household income of such family. A State shall establish income eligibility thresholds for populations to be eligible for medical assistance under the State plan or under any waiver of such plan for any other purpose applicable under the plan or waives for which a determination of income is not required, including with respect to the imposition of premiums and cost-sharing, a State shall use the modified gross income of an individual and, in the case of an individual in a family greater than one, the household income of such family. A State shall establish income eligibility thresholds for populations to be eligible for medical assistance under the State plan or under any waiver of such plan for any other purpose applicable under the plan or waives for which a determination of income is not required, including with respect to the imposition of premiums and cost-sharing, a State shall use the modified gross income of an individual and, in the case of an individual in a family greater than one, the household income of such family. A State shall establish income eligibility thresholds for populations to be eligible for medical assistance under the State plan or under any waiver of such plan for any other purpose applicable under the plan or waives for which a determination of income is not required, including with respect to the imposition of premiums and cost-sharing, a State shall use the modified gross income of an individual and, in the case of an individual in a family greater than one, the household income of such family. A State shall establish income eligibility thresholds for populations to be eligible for medical assistance under the State plan or under any waiver of such plan for any other purpose applicable under the plan or waives for which a determination of income is not required, including with respect to the imposition of premiums and cost-sharing, a State shall use the modified gross income of an individual and, in the case of an individual in a family greater than one, the household income of such family. A State shall establish income eligibility thresholds for populations to be eligible for medical assistance under the State plan or under any waiver of such plan for any other purpose applicable under the plan or waives for which a determination of income is not required, including with respect to the imposition of premiums and cost-sharing, a State shall use the modified gross income of an individual and, in the case of an individual in a family greater than one, the household income of such family.
this title and title XXI as are necessary to ensure that States establish income and eligibility determination systems that protect beneficiaries. “(B) NO INCOME OR EXPENSE DISREGARDS.—No type of expense, block, or other income disregard shall be applied by a State to determine income eligibility for medical assistance under the State plan or under any waiver of such plan or for any other purpose applicable under the plan or waiver for which a determination of income is required. “(C) NO ASSET TEST.—A State shall not apply any assets or resources test for purposes of determining eligibility for medical assistance under the State plan or under a waiver of the plan. “(D) EXCEPTIONS.— “(1) INDIVIDUALS ELIGIBLE BECAUSE OF OTHER INCOME, ELDERLY INDIVIDUALS, MEDICALLY NEEDED INDIVIDUALS, AND INDIVIDUALS ELIGIBLE FOR MEDICARE COST-SHARING.—Subparagraphs (A), (B), and (C) shall not apply to the determination of eligibility under the State plan or under a waiver for medical assistance for the following: “(I) Individuals who are eligible for medical assistance under the State plan or under any waiver of the plan on a basis that does not require a determination of income by the State agency administering the State plan or waiver for a result of being blind or disabled. “(ii) EXPRESS LANE AGENCY FINDINGS.—In the case of a State electing the Express Lane option under paragraph (13), notwithstanding subparagraphs (A), (B), and (C), the State may rely on a finding made by an Express Lane agency or agencies for purposes of making such determinations as the State used on the date of enactment of the Patient Protection and Affordable Care Act. The Secretary shall ensure that such procedures are consistent with section 1915(h)(2)(B) under the State plan or a waiver of the plan. “(I) Individuals who are eligible for medical assistance under the State plan or under any waiver of such plan on the basis of being blind or disabled (or being treated as being blind or disabled) without regard to whether the individual is eligible for supplemental security income benefits under title XVI, and individuals who are eligible as a result of being or being deemed to be a child in foster care under the responsibility of the State. “(II) Individuals who have attained age 65. “(III) Individuals who qualify for medical assistance under the State plan or under any waiver of such plan on the basis of the loss of income and assets of the individual or the individual’s family by reason of the death of the individual or a family member. “(IV) Individuals described in subsection (a)(10)(C).” (f) REQUIREMENTS FOR STATES TO USE MODIFIED GROSS INCOME AND HOUSEHOLD INCOME.—The Secretary shall not waive compliance with the requirements of this paragraph except to the extent necessary to permit a State to coordinate eligibility requirements for dual eligible individuals (as defined in section 1915(h)(2)(B)) under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act no longer being eligible for such assistance. “(1) DEFINITIONS OF MODIFIED GROSS INCOME AND HOUSEHOLD INCOME.—In this paragraph, the terms ‘modified gross income’ and ‘household income’ have the meanings given in section 36B(d)(2) of the Internal Revenue Code of 1986. “(2) RULES REGARDING POINT-IN-TIME INCOME AND SOURCES OF INCOME.—The requirement under this paragraph for States to use modified gross income and household income to determine income eligibility for medical assistance under the State plan or under any waiver of such plan and for any other purpose applicable under which determination of income is required shall not be construed as affecting or limiting the application of the following rules: “(i) The requirement under this title and under the State plan or a waiver of the plan to determine an individual’s income as of the point in time at which an application for medical assistance under the State plan or a waiver of the plan is processed; or “(ii) any rules established under this title or under the State plan or a waiver of the plan regarding the effect of certain income. “(B) CONFORMING AMENDMENTS.—Section 1902(a)(30) of such Act (42 U.S.C. 1396a(a)(17)) is amended by inserting ‘(e)(14)’, before ‘(1)(3)’. SEC. 2004. MEDICAID COVERAGE FOR FORMER Foster Care Children.— “(a) IN GENERAL.—Section 1902(a)(10)(A)(i) of the Social Security Act (42 U.S.C. 1396a), as amended by section 2001(a)(1), is amended— “(1) by striking ‘or’ at the end of subclause (VII); “(2) by adding ‘or’ at the end of subclause (VIII); “(3) by inserting ‘and’ after ‘after’ and inserting ‘and’ after ‘after’; and “(4) in subsection (e), by striking ‘under age 19’ each place it appears. “(b) CONFORMING AMENDMENTS.—The heading for section 1902(a)(4)(B) of such Act (42 U.S.C. 1396a-1) is amended by striking ‘OPTION FOR CHILDREN’.” SEC. 2005. EFFECTIVE DATE.—The amendments made by this section take effect on January 1, 2014.
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(3) by adding at the end the following paragraph:

“(5) FISCAL YEAR 2011 AND THEREAFTER.—The amounts otherwise determined under this subsection for fiscal years beginning after fiscal year 2011, and for each fiscal year after fiscal year 2011 (after the application of subsection (f) and the preceding paragraphs of this subsection), shall be increased by 30 percent.

(b) DISREGARD OF PAYMENTS FOR MANDATORY EXPANDED ENROLLMENT.—Section 1109(g)(4) of such Act (42 U.S.C. 1309(g)(4)) is amended by striking 

“(1) by striking “to fiscal years beginning” and inserting “to”;

“(A) fiscal years beginning;”;

(by striking the period at the end and inserting “;” and “);” and

(3) by adding at the end the following:

“(B) fiscal years beginning with fiscal year 2011, payments made to Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa with respect to amounts expended for medical assistance for newly eligible persons under section 1905(y)(2) nonpregnant childless adults who are eligible under subclause (VIII) of section 1902(a)(10)(A)(ii) and whose income (as determined under section 1902(e)(14)) does not exceed (in the case of each such commonwealth and territory respectively) the income eligibility level in effect for that population under the State child health plan (including any waiver granted under this subsection), the Federal medical assistance percentage determined for the fiscal year without regard to this subsection and subsection (y), and subsections (b) and (c) of section 5001 of Public Law 111–5, by at least 3 percentage points; and

(B) in the case of the second or any succeeding fiscal year for which this subsection applies to the State, the Federal medical assistance percentage determined for the fiscal year without regard to this subsection and subsection (y), is less than the Federal medical assistance percentage determined for the State for the preceding fiscal year under this subsection by at least 3 percentage points.

“(3) The Federal medical assistance percentage determined for a disaster-recovery FMAP adjustment State under paragraph (1) shall apply for the fiscal year (other than with respect to disproportionate share hospital payments described in section 1923 payments under this title that are based on the enhanced FMAP determined for a State for a fiscal year under this subsection by at least 3 percentage points).

“(B) in clause (iv), by striking the period 

“(3) CONTINUATION OF ELIGIBILITY STANDARDS FOR CHILDREN UNTIL OCTOBER 1, 2019.—

“(A) IN GENERAL.—During the period that begins on the date of enactment of the Patient Protection and Affordable Care Act and ends on September 30, 2019, a State shall not have in effect eligibility standards, methodologies, or procedures under its State child health plan (including any waiver under such plan) for children (including children provided medical assistance for which payment is made under such a waiver) that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under such plan or waiver as in effect on the date of enactment of such Act. The preceding sentence shall not be construed as preventing a State during such period from—

“(A) applying eligibility standards, methodologies, or procedures for children under the State child health plan or any waiver of the plan that are less restrictive than the eligibility methodologies, or procedures, respectively, for children under the plan or waiver that are in effect on the date of enactment of such Act; or

“(ii) imposing a limitation described in section 1121(b)(7) for a fiscal year in order to limit expenditures under the State child health plan to those for which Federal financial participation is available under this section for the fiscal year.

“(B) ASSURANCE OF EXCHANGE COVERAGE FOR TARGETED LOW-INCOME CHILDREN UNABLE TO OBTAIN HEALTH INSURANCE AS A RESULT OF FUNDING SHORTFALLS.—In the event that allotments provided under section 2104 are insufficient to provide coverage to children who are newly eligible for coverage or targeted low-income children through the State child health plan under this title, a State shall establish procedures to ensure that such children are provided coverage through an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act.

“TWO MEDICAID IMPROVEMENT FUND RE-USE.

(a) RESCSSION.—Any amounts available to the Medicaid Improvement Fund established under section 1905(b)(5) of the Social Security Act (42 U.S.C. 1396w–1) for any fiscal years 2014 through 2018 that are available for expenditure from the Fund and that are not obligated as of the date of enactment of this Act are rescinded.

(b) CONFORMING AMENDMENTS.—Section 1911(b)(1) of the Social Security Act (42 U.S.C. 1396w–14) is amended—

(1) in subparagraph (A), by striking “$150,000,000” and inserting “$0”; and

(2) in subparagraph (B), by striking “$150,000,000” and inserting “$0”.

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

SECTION 2101. ADDITIONAL FEDERAL FINANCIAL PARTICIPATION FOR CHIP.

(a) IN GENERAL.—Section 1905(b)(2) of the Social Security Act (42 U.S.C. 1396d(b)) is amended by adding at the end the following:

“Notwithstanding the preceding sentence, during the period that begins on October 1, 2013, and ends on September 30, 2019, the enhanced FMAP determined for a State for a fiscal year (or for any portion of a fiscal year occurring during such period) shall be increased by 25 percentage points, but in no event shall the enhanced FMAP under the preceding sentence not apply with respect to determining the payment to a State under subsection (v)(1) for any period occurring during such period.

(b) MAINTENANCE OF ENROLLMENT.—

(1) IN GENERAL.—Section 2105(d) of the Social Security Act (42 U.S.C. 1397eed(d)) is amended by adding at the end the following:

“Continuation of eligibility standards for children until October 1, 2019.—

“(A) IN GENERAL.—During the period that begins on the date of enactment of the Patient Protection and Affordable Care Act and ends on September 30, 2019, a State shall not have in effect eligibility standards, methodologies, or procedures under its State child health plan (including any waiver under such plan) for children (including children provided medical assistance for which payment is made under such a waiver) that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under such plan or waiver as in effect on the date of enactment of such Act. The preceding sentence shall not be construed as preventing a State during such period from—

“(A) applying eligibility standards, methodologies, or procedures under the State child health plan or any waiver of the plan that are less restrictive than the eligibility methodologies, or procedures, respectively, for children under the plan or waiver that are in effect on the date of enactment of such Act; or

“(ii) imposing a limitation described in section 1121(b)(7) for a fiscal year in order to limit expenditures under the State child health plan to those for which Federal financial participation is available under this section for the fiscal year.

“(B) ASSURANCE OF EXCHANGE COVERAGE FOR TARGETED LOW-INCOME CHILDREN UNABLE TO OBTAIN HEALTH INSURANCE AS A RESULT OF FUNDING SHORTFALLS.—In the event that allotments provided under section 2104 are insufficient to provide coverage to children who are newly eligible for coverage or targeted low-income children through the State child health plan under this title, a State shall establish procedures to ensure that such children are provided coverage through an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act.

“CONFORMING AMENDMENT TO TITLE XXI MEDICAID MAINTENANCE OF EFFORT.—Section 2105(d)(1) of the Social Security Act (42 U.S.C. 1397eed(d)(1)) is amended by adding before the period “except as required under section 1902(e)(14)” the following:—

“(c) NO ENROLLMENT BONUS PAYMENTS FOR CHILDREN ENROLLED AFTER FISCAL YEAR 2013.—Section 2105(a)(3)(F)(iiii) of the Social Security Act (42 U.S.C. 1397eed(a)(3)(F)(iiii)) is amended by inserting “or any children enrolling on or after October 1, 2013” before the period;”.

(d) INCOME ELIGIBILITY DETERMINED USING MODIFIED GROSS INCOME.—

PLANE REQUIREMENT.—Section 2102(b)(1) of the Social Security Act (42 U.S.C. 1397bb(b)(1)) is amended—

(A) in clause (iii), by striking “and” after the period; and

(B) in clause (iv), by striking the period and inserting “; and”; and
(C) by adding at the end the following: 

"(v) shall, beginning January 1, 2014, use modified gross income and household income (as defined in section 56(b)(2) of the Internal Revenue Code of 1986) to determine eligibility for child health assistance under the State child health plan or under any waiver of such plan and for any other purpose applicable for which a determination of income is required, including with respect to the imposition of premiums and cost-sharing, consistent with section 1903(a)(14)."

(2) CONFORMING AMENDMENT.—Section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397g(e)(1)) is amended—

(A) by redesigning subparagraphs (E) through (L) as subparagraphs (F) through (M), respectively; and

(B) by inserting after subparagraph (D), the following:

"(E) Section 1902(e)(14) (relating to income determined using modified gross income and household income),".

(e) APPLICATION OF STREAMLINED ENROLLMENT SYSTEM.—Section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397g(e)(1)), as amended by section (d)(2), is amended by adding at the end the following:

"(N) Section 1943(b) (relating to coordination with State Exchanges and the State Medicaid agency)."

(1) ELIGIBILITY FOR CHILDREN INELIGIBLE FOR MEDICAID AS A RESULT OF ELIMINATION OF DISREGARDS.—Notwithstanding any other provision of law, a State shall treat any child who is determined to be ineligible for medical assistance under the State Medicaid plan or under a waiver of the plan as a result of the elimination of the application of income disregards based on expense or type of income, as required under section 1902(e)(14) of the Social Security Act (as added by this Act), as a targeted low-income child under section 1902(e)(14)(B) (unless the child is excluded under paragraph (2) of that section) and shall provide child health assistance to the child under the State child health plan (whether implemented under title XIX or XXI, or both, of the Social Security Act).

SEC. 2102. TECHNICAL CORRECTIONS.

(a) CHIPRA.—Effective as if included in the enactment of the Children’s Health Insurance Program Reauthorization Act of 2009 (Public Law 111–3) (in this section referred to as “CHIPRA”):

(1) Section 2104(m) of the Social Security Act, as added by section 102 of CHIPRA, is amended—

(A) by redesigning paragraph (7) as paragraph (8); and

(B) by inserting after paragraph (6), the following:

"(7) ADJUSTMENT OF FISCAL YEAR 2010 ALLOTMENTS TO ACCOUNT FOR CHANGES IN PROJECTED SPENDING FOR CERTAIN PREVIOUSLY APPROVED EXPANSION PROGRAMS.—For purposes of the fiscal year 2010 allotment, in the case of one of the 50 States or the District of Columbia that has an approved State plan amendment effective January 1, 2006, to provide child health assistance through the provision of benefits under the State plan under title XIX for children from birth through age 5 whose family income does not exceed 200 percent of the poverty line, the Secretary shall increase the allotment by an amount that would be equal to the Federal share of expenditures that would have been incurred under the Fiscal Year 2010 FMAP rate rather than the Federal medical assistance percentage matching rate for such population.

(2) Section 605 of CHIPRA is amended by striking “legal resident” and inserting “lawfully residing in the United States”.

(3) Subclauses (I) and (II) of paragraph (3)(C) of section 2105(a) of the Social Security Act (42 U.S.C. 1397e(a)(3)(i)), as added by section 104 of CHIPRA, are each amended by striking “—

(b) ENROLLMENT SIMPLIFICATION AND COORDINATION WITH STATE HEALTH INSURANCE EXCHANGES.—The State Medicaid agency (or a State CHIP agency) may determine whether an individual is capable of enrolling, without any further determination of eligibility, child health assistance under the State child health plan under title XXI, including children, unaccompanied homeless youth, children and youth with special health care needs, pregnant women, victims of abuse or trauma, individuals with mental health or substance-related disorders, and individuals with HIV/AIDS.

(2) AGREEMENTS WITH STATE HEALTH INSURANCE EXCHANGES.—The Medicaid agency and the State CHIP agency may enter into an agreement with an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act under which the State Medicaid agency or State CHIP agency may determine whether a State resident is eligible for premium assistance for the purchase of a qualified health plan under section 36B of the Internal Revenue Code of 1986 (and, if applicable, advance payment of such assistance under section 1412 of the Patient Protection and Affordable Care Act), and, if eligible, enrolled in such a plan without having to submit an additional or separate application, enrollment form, or other information regarding reduced cost-sharing for eligible individuals under section 1402 of the Patient Protection and Affordable Care Act, and any other assistance or subsidies available for coverage obtained through the Exchange;

(“D) ensuring that the State agency responsible for administering the State plan under this title (in this section referred to as the “State Medicaid agency”), the State agency responsible for administering the State child health plan under title XXI (in this section referred to as the “State CHIP agency”), and an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act, and any other assistance or subsidies available for coverage obtained through the Exchange;
SEC. 2202. COVERAGE FOR FREESTANDING BIRTH CENTER SERVICES.

(a) IN GENERAL.—Section 1902(a)(47) of the Social Security Act (42 U.S.C. 1396a(a)(47)) is amended—

(1) by striking “section (i)” and inserting “section Ja”; and

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

“(ii) that complies with such other requirements relating to the health and safety of individuals furnished services by the facility as the State shall establish.”

(b) CONFORMING AMENDMENT.—Section 1902(a)(47)(B) to be a qualified entity for such purpose.”.

c) EFFECTIVE DATE.—The amendments made by this section take effect on January 1, 2014, in order to provide the benefits furnished on or after that date.

Subtitle D—Improvements to Medicaid Services

SEC. 2201. COVERAGE FOR FREESTANDING BIRTH CENTER SERVICES.

(a) IN GENERAL.—Section 1902 of the Social Security Act (42 U.S.C. 1396d) is amended—

(1) in subsection (a)—

(A) in paragraph (27), by striking “and” at the end;

(B) by redesignating paragraph (28) as paragraph (29); and

(C) by inserting after paragraph (27) the following new paragraph:

“(28) freestanding birth center services (as defined in subsection (1)(B)(ii)) and other ambulatory services that are offered by a freestanding birth center (as defined in subsection (1)(B)(ii)) and that are otherwise included in the plan; and”;

(2) in subsection (b), by adding at the end the following new paragraph:

“(3)(A) The term ‘freestanding birth center services’ means services furnished to an individual that is not a hospital; (i) that is not a hospital; (ii) where childbirth is planned to occur away from the pregnant woman’s residence; (iii) that is licensed or otherwise approved by the State to provide prenatal labor and delivery or postpartum care and other ambulatory services that are included in the plan; and (iv) that complies with such other requirements relating to the health and safety of individuals furnished services by the facility as the State shall establish.”

(b) CONFORMING AMENDMENT.—Section 1902(a)(47)(B) to be a qualified entity for such purpose.”.

(c) EFFECTIVE DATE.—The amendments made by this section shall not be construed as changing the additional requirement imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 2202. CONCURRENT CARE FOR CHILDREN.

(a) IN GENERAL.—Section 1906(e)(1) of the Social Security Act (42 U.S.C. 1396d(e)(1)) is amended—

(1) in subparagraph (A), by striking “(paragraph (B)” and inserting “paragraphs (B) and (C)”;

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

“(C) A voluntary election to have payment made for hospice care for a child (as defined by the State) shall not constitute a waiver of any rights of the child to be provided, or to have payment made under this title for services that are not provided to meet the child’s condition for which a diagnosis of terminal illness has been made.”.

(b) APPLICATION TO CHIP.—Section 2101(b)(1)(D) of the Social Security Act (42 U.S.C. 1396p(a)(29)) is amended by inserting “concurrent, in the case of a child who is a child, with care related to the treatment of the child’s condition with respect to which a diagnosis of terminal illness has been made” after “hospice care”.

SEC. 2203. STATE ELIGIBILITY OPTION FOR FAMILY PLANNING SERVICES.

(a) COVERAGE AS OPTIONAL CATEGORY OF NEEDY GROUP.—

(1) IN GENERAL.—Section 1902(a)(10)(A)(ix) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ix)) is amended—

(A) by redesignating paragraph (a) as paragraph (a)(1); and

(B) by striking “and” at the end of clause (ii) of paragraph (a)(1) and inserting “or” in its place;

(C) by striking “and” at the end of clause (ii) of paragraph (a)(2) and inserting “or” in its place;

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

“(XXI) who are described in subsection (ii);”.

(b) CONFORMING AMENDMENT.—Section 1902(a)(10) of the Social Security Act (42 U.S.C. 1396a(a)(10)), as amended by section 2001(e), is amended—

(1) in subsection (A)(i), by striking “(XIX)” and inserting “(XIX);”;

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

“(XXI) who are described in subsection (ii) (relating to individuals who meet certain income standards)”.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this subsection shall take effect—

(A) on the date of the enactment of this Act and shall apply to services furnished on or after such date.

(2) EXPIRATION.—If State legislation required for purposes of this section is not enacted by the date of the enactment of this Act and shall apply to services furnished on or after such date.

(3) LIMITATION ON BENEFITS.—Section 1902(a)(10) of the Social Security Act (42 U.S.C. 1396a(a)(10)) is amended by inserting “or” after “or” at the end of clause (vii) of paragraph (a) and striking “and” after “(8)” and inserting “(8)” in its place.

(4) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall not be construed as changing the provisions of such title solely on the basis of its failure to meet this requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

(5) CONFORMING AMENDMENT.—Section 1902(a)(10)(A)(ix) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ix)) is amended by inserting “or” after “or” at the end of clause (vii) of paragraph (a) and striking “and” after “(8)” and inserting “(8)” in its place.

(6) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after such date.

(7) CONFORMING AMENDMENT.—Section 1902(a)(10)(A)(ix) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ix)) is amended by inserting “or” after “or” at the end of clause (vii) of paragraph (a) and striking “and” after “(8)” and inserting “(8)” in its place.

(8) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this subsection shall take effect—

(A) on the date of the enactment of this Act and shall apply to services furnished on or after such date.

(2) EXPIRATION.—If State legislation required for purposes of this section is not enacted by the date of the enactment of this Act and shall apply to services furnished on or after such date.

(3) LIMITATION ON BENEFITS.—Section 1902(a)(10) of the Social Security Act (42 U.S.C. 1396a(a)(10)) is amended by inserting “or” after “or” at the end of clause (vii) of paragraph (a) and striking “and” after “(8)” and inserting “(8)” in its place.

(4) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall not be construed as changing the provisions of such title solely on the basis of its failure to meet this requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

(5) CONFORMING AMENDMENT.—Section 1902(a)(10)(A)(ix) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ix)) is amended by inserting “or” after “or” at the end of clause (vii) of paragraph (a) and striking “and” after “(8)” and inserting “(8)” in its place.

(6) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after such date.

(7) CONFORMING AMENDMENT.—Section 1902(a)(10)(A)(ix) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ix)) is amended by inserting “or” after “or” at the end of clause (vii) of paragraph (a) and striking “and” after “(8)” and inserting “(8)” in its place.
SEC. 2027.

(a) General.—(1) Presumptive Eligibility Period.—The State agency, in consultation with the State Medicaid and CHIP Payment and Access Commission, shall provide a presumptive eligibility period for an individual described in section 1902(a)(10) (A)(i)(I) to apply for medical assistance under the State plan; and

(2) Application for Medical Assistance.—In the case of an individual described in subsection (a) who is determined by a qualified entity that determines under subsection (a) to be presumptively eligible for medical assistance under a State plan, the following provisions shall apply:

(A) The State agency shall record the information provided by the individual concerning the presumption and shall take such actions as necessary to determine eligibility for medical assistance under the State plan and the assistance that the individual is eligible to receive.

(B) The State agency shall make a determination of eligibility not later than 10 business days after the date on which the information is furnished, and shall notify the individual of the determination within 10 days of its receipt.

(C) The State agency shall provide the individual with a certificate of eligibility or noneligibility.

SEC. 2028.

(a) General.—(1) Presumptive Eligibility Period.—The State agency, in consultation with the State Medicaid and CHIP Payment and Access Commission, shall provide a presumptive eligibility period for an individual described in section 1902(a)(10) (A)(i)(I) to apply for medical assistance under the State plan; and

(2) Application for Medical Assistance.—In the case of an individual described in subsection (a) who is determined by a qualified entity that determines under subsection (a) to be presumptively eligible for medical assistance under a State plan, the following provisions shall apply:

(A) The State agency shall record the information provided by the individual concerning the presumption and shall take such actions as necessary to determine eligibility for medical assistance under the State plan and the assistance that the individual is eligible to receive.

(B) The State agency shall make a determination of eligibility not later than 10 business days after the date on which the information is furnished, and shall notify the individual of the determination within 10 days of its receipt.

(C) The State agency shall provide the individual with a certificate of eligibility or noneligibility.

SEC. 2029.

(a) General.—(1) Presumptive Eligibility Period.—The State agency, in consultation with the State Medicaid and CHIP Payment and Access Commission, shall provide a presumptive eligibility period for an individual described in section 1902(a)(10) (A)(i)(I) to apply for medical assistance under the State plan; and

(2) Application for Medical Assistance.—In the case of an individual described in subsection (a) who is determined by a qualified entity that determines under subsection (a) to be presumptively eligible for medical assistance under a State plan, the following provisions shall apply:

(A) The State agency shall record the information provided by the individual concerning the presumption and shall take such actions as necessary to determine eligibility for medical assistance under the State plan and the assistance that the individual is eligible to receive.

(B) The State agency shall make a determination of eligibility not later than 10 business days after the date on which the information is furnished, and shall notify the individual of the determination within 10 days of its receipt.

(C) The State agency shall provide the individual with a certificate of eligibility or noneligibility.

SEC. 2030.

(a) General.—(1) Presumptive Eligibility Period.—The State agency, in consultation with the State Medicaid and CHIP Payment and Access Commission, shall provide a presumptive eligibility period for an individual described in section 1902(a)(10) (A)(i)(I) to apply for medical assistance under the State plan; and

(2) Application for Medical Assistance.—In the case of an individual described in subsection (a) who is determined by a qualified entity that determines under subsection (a) to be presumptively eligible for medical assistance under a State plan, the following provisions shall apply:

(A) The State agency shall record the information provided by the individual concerning the presumption and shall take such actions as necessary to determine eligibility for medical assistance under the State plan and the assistance that the individual is eligible to receive.

(B) The State agency shall make a determination of eligibility not later than 10 business days after the date on which the information is furnished, and shall notify the individual of the determination within 10 days of its receipt.

(C) The State agency shall provide the individual with a certificate of eligibility or noneligibility.

SEC. 2031.

(a) General.—(1) Presumptive Eligibility Period.—The State agency, in consultation with the State Medicaid and CHIP Payment and Access Commission, shall provide a presumptive eligibility period for an individual described in section 1902(a)(10) (A)(i)(I) to apply for medical assistance under the State plan; and

(2) Application for Medical Assistance.—In the case of an individual described in subsection (a) who is determined by a qualified entity that determines under subsection (a) to be presumptively eligible for medical assistance under a State plan, the following provisions shall apply:

(A) The State agency shall record the information provided by the individual concerning the presumption and shall take such actions as necessary to determine eligibility for medical assistance under the State plan and the assistance that the individual is eligible to receive.

(B) The State agency shall make a determination of eligibility not later than 10 business days after the date on which the information is furnished, and shall notify the individual of the determination within 10 days of its receipt.

(C) The State agency shall provide the individual with a certificate of eligibility or noneligibility.

SEC. 2032.

(a) General.—(1) Presumptive Eligibility Period.—The State agency, in consultation with the State Medicaid and CHIP Payment and Access Commission, shall provide a presumptive eligibility period for an individual described in section 1902(a)(10) (A)(i)(I) to apply for medical assistance under the State plan; and

(2) Application for Medical Assistance.—In the case of an individual described in subsection (a) who is determined by a qualified entity that determines under subsection (a) to be presumptively eligible for medical assistance under a State plan, the following provisions shall apply:

(A) The State agency shall record the information provided by the individual concerning the presumption and shall take such actions as necessary to determine eligibility for medical assistance under the State plan and the assistance that the individual is eligible to receive.

(B) The State agency shall make a determination of eligibility not later than 10 business days after the date on which the information is furnished, and shall notify the individual of the determination within 10 days of its receipt.

(C) The State agency shall provide the individual with a certificate of eligibility or noneligibility.
“(i) the acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish activities of daily living, instrumental activities of daily living, and household chores; “(ii) back-up systems or mechanisms (such as the use of beepers or other electronic devices) to ensure continuity of services and supports made available; “(iii) voluntary training on how to select, manage, and dismiss attendants; “(C) EXCLUDED SERVICES AND SUPPORTS.—Subject to paragraph (D), the home and community-based attendant services and supports made available do not include— “(i) room and board costs for the individual; “(ii) special education and related services provided under the Individuals with Disabilities Education Act and vocational rehabilitation services provided under the Rehabilitation Act of 1973; “(iii) assistive technology devices and services to individuals with disabilities, elderly individuals, and others and maximizes consumer independence and consumer control; “(iv) monitors the health and well-being of each individual who receives home and community-based attendant services and supports, including a process for the mandatory reporting, investigation, and resolution of allegations of neglect, abuse, or exploitation in connection with the provision of such services and supports; and “(iv) provides information about the provisions required under the clauses (i) through (iii) to each individual receiving such services; and “(B) C O MPLIANCE WITH CERTAIN LAWS.—A State shall ensure that, regarding the terms ‘activities of daily living’ includes tasks such as eating, toileting, grooming, dressing, bathing, and other activities that allow the individual, or where appropriate, the individual’s representative, maximum control of the home and community-based services and supports, regardless of who acts as the employer of record. “(C) DELIVERY MODELS.—The term ‘agency-provider model’ means, with respect to the provision of home and community-based attendant services and supports for an individual, subject to paragraph (A), a method of providing consumer controlled services and supports, with respect to the choice to receive home and community-based services, including home and community-based attendant services and supports under a State plan amendment under this subsection for each fiscal year for which such services and supports are provided: “(i) The number of individuals who are entitled to receive home and community-based attendant services and supports under this subsection during the fiscal year; “(ii) The number of individuals that receive such services and supports during the preceding fiscal year; “(iii) The specific number of individuals served by type of disability, age, gender, education level, and employment status. “(D) OVERSIGHT AND ASSESSMENT OF THE ADMINISTRATION OF HOME AND COMMUNITY-BASED SERVICES.—The Secretary of Health and Human Services may implement regulations to ensure that all States develop service systems that are designed to—
(1) allocate resources for services in a manner that is responsive to the changing needs and choices of beneficiaries receiving non-institutionally-based long-term services and supports that are provided under programs other than the State Medicaid program, and that provides strategies for beneficiaries receiving such services and supports to maximize their independence, including through the use of client-employed providers;
(2) provide the support and coordination needed to identify the need of such services (and their family caregivers or representative, if applicable) to design an individually directed, community-supported life; and
(3) improve coordination among, and the regulation of, all providers of such services under federally and State-funded programs in order to—
(A) achieve a more consistent administration of policies and procedures across programs in addition to the provision of such services; and
(B) oversee and monitor all system service functions to assure—
(i) coordination of, and effectiveness of, eligibility determinations and individual assessments;
(ii) development and service monitoring of a care management, a management system, a system to qualify and monitor providers, and systems for role-setting and individual budget determinations; and
(iii) decrease the number of qualified direct care workers to provide self-directed personal assistance services.

(b) Additional State Options.—Section 1915(d) of the Social Security Act (42 U.S.C. 1396n(i)) is amended by adding at the end the following new paragraphs:
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Subtitle F—Medicaid Prescription Drug Coverage

SEC. 2501. PRESCRIPTION DRUG REBATES.

(a) INCREASE IN MINIMUM REBATE PERCENTAGE FOR SINGLE SOURCE DRUGS AND INNOVATOR MULTIPLE SOURCE DRUGS.—

(1) IN GENERAL.—Section 1927(c)(1)(B) of the Social Security Act (42 U.S.C. 1396r–8(c)(1)(B)) is amended—

(A) in clause (i)—

(i) in subclause (IV), by striking “at the end” and inserting “at the end, and”; and

(ii) in clause (V), by striking “and” and inserting “and”;

and

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

“(VI) except as provided in clause (III), after December 31, 2009, 23.1 percent.”;

and

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

(1) in clause (i), by striking “at the end” and inserting “at the end, and”;

(2) in clause (ii)—

(A) by inserting “and before January 1, 2010,” after “December 31, 1993,”; and

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

and

(3) by adding at the end the following new clause:

“(C) TREATMENT OF NEW FORMULATIONS.—

“(1) IN GENERAL.—Section 1903(m)(2)(A) of such Act (42 U.S.C. 1396m(m)(2)(A)) is amended—

(A) in clause (xi), by striking “at the end” and;

(B) in clause (xii), by striking the period at the end and inserting “; and”;

and

(C) by adding at the end the following:

“(xiii) such contract provides that (I) covered outpatient drugs dispensed to individuals eligible for medical assistance who are enrolled in a Medicaid managed care organization if the organization is responsible for coverage of such drug under this subsection (other than covered outpatient drugs that under subsection (j)(1) of section 1927 are not subject to requirements of that section) and such other data as the Secretary determines necessary to carry out this subsection.”.

SEC. 2502. SENSE OF THE SENATE REGARDING LONG-TERM CARE.

(a) FINDINGS.—The Senate makes the following findings:

(1) Nearly 2 decades have passed since Congress seriously considered long-term care reform. The United States Bipartisan Commission on Comprehensive Health Care, also known as the “Pepper Commission,” released its “Call for Action” blueprint for health reform in September 1990. In the 20 years since those recommendations were made, Congress has never acted on the report.

(2) In 1999, under the United States Supreme Court’s decision in Olmstead v. L.C., 527 U.S. 581 (1999), individuals with disabilities have the right to choose to receive their long-term services and supports in the community, rather than in an institutional setting.

(3) Despite the Pepper Commission and Olmstead decision, the long-term care provided to our Nation’s elderly and disabled has not improved. In fact, for many, it has gotten worse.

(4) In 2007, 69 percent of Medicaid long-term care spending for elderly individuals and adults with physical or mental disabilities paid for institutional services. Only 6 states spent 50 percent or more of their Medicaid long-term care dollars on home and community-based services for elderly individuals and adults with physical disabilities while ½ of the States spent less than 25 percent. This disparity continues even though, on average, it is estimated that Medicaid dollars can support nearly 3 elderly individuals and adults with physical disabilities in home and community-based services for every individual in a nursing home. Although every State has chosen to provide certain services under home and community-based waivers, these services are unevenly available within and across States, and reach a small percentage of eligible individuals.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that—

(1) during the 111th session of Congress, Congress should address the needs of elderly and disabled individuals and support in a comprehensive way that guarantees elderly and disabled individuals the care they need; and

(2) decisions by drug companies and supports should be made available in the community in addition to institutions.
“(I) IN GENERAL.—Except as provided in clause (ii), in the case of a drug that is a new formulation, such as an extended-release formulation, of a single source drug or an innovator multiple source drug, the rebate obligation with respect to the drug under this section shall be the amount computed under this section for the new formulation of the drug as if—

(I) the average manufacturer price for each dosage form and strength of the new formulation of the single source drug or innovator multiple source drug is—

(II) the highest additional rebate (calculated as a percentage of average manufacturer price) under this section for any strength or dosage form of a single source drug or innovator multiple source drug; and

(III) the total number of units of each dosage form and strength of the new formulation paid for under the State plan in the rebate period (as reported by the State).

“(II) No Application to New Formulations of Orphan Drugs.—Clause (i) shall not apply to a new formulation of a covered outpatient drug that is or has been designated under section 528 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bb) for a rare disease or condition not for the single source drug or innovator multiple source drug; and

“(III) Maximum Rebate Amount.—Section 1927(c)(2) of such Act (42 U.S.C. 1396r–8(c)(2)), as amended by subsection (d), is amended by adding at the end the following new subparagraph:

“(D) Maximum rebate amount.—In no case shall the sum of the amounts applied under paragraph (1) and this paragraph with respect to each dosage form and strength of a single source drug or an innovator multiple source drug for a rebate period beginning after December 31, 2009, exceed 100 percent of the average manufacturer price of the drug.”.

(f) Conforming Amendments.—

(1) IN GENERAL.—Section 310B of the Public Health Service Act (22 U.S.C. 265b) is amended—

(A) by striking subsection (2), and

(B) by redesignating subsection (3) as subsection (2); and

(2) EFFECTIVE DATE.—The amendments made by this section take effect on January 1, 2010.

SECTION 2502. ELIMINATION OF EXCLUSION OF COVERAGE OF CERTAIN DRUGS.

(a) IN GENERAL.—Section 1927(d) of the Social Security Act (42 U.S.C. 1397r–6(d)) is amended—

(I) in paragraph (2)—

(A) by striking subparagraphs (E), (I), and (J), respectively; and

(B) by redesignating subparagraphs (F), (G), (H), and (K) as subparagraphs (E), (F), (G), and (H), respectively; and

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

“(7) Non-excludable drugs.—The following drugs or classes of drugs, or their medical uses, shall not be excluded from coverage:

(A) Agents when used to promote smoking cessation, including agents approved by the Food and Drug Administration under the over-the-counter monograph process for purposes of promoting, and when used to promote, tobacco cessation.

(B) Barbiturates.

(C) Benzodiazepines.”.

(b) Effective Date.—The amendments made by this section shall apply to services furnished on or after January 1, 2014.

SEC. 2503. PROVIDING ADEQUATE PHARMACY REIMBURSEMENT LIMITS.

(a) Pharmacy Rebate Limitation.—

(I) IN GENERAL.—Section 1927(e) of the Social Security Act (42 U.S.C. 1397r–6(e)) is amended—

(A) in paragraph (4), by striking “(or, effective January 1, 2007, two or more)”; and

(B) by striking paragraph (5) and inserting the following:

“(6) Use of AMP in Upper Payment Limits.—The Secretary shall calculate the Federal upper reimbursement limit established under paragraph (4) as no less than 175 percent of the average manufacturer price for the drug (as determined on the basis of utilization) of the most recently reported monthly average manufacturer prices for pharmaceutically and therapeutically equivalent multiple source drug products that are available for purchase by retail community pharmacies on a nationwide basis. The Secretary shall implement a smoothing process for average manufacturer prices. Such process shall be similar to the smoothing process used in determining the average sales price of a drug or biological under section 1927(a).

(2) Definition of AMP.—Section 1927(k)(1) of such Act (42 U.S.C. 1396r–8(k)(1)) is amended—

(A) in subparagraph (A), by striking “by” and inserting “by”;

(B) by striking subparagraph (B) and inserting the following:

“(i) wholesalers for drugs distributed to retail community pharmacies; and

(ii) retail community pharmacies that purchase drugs directly from the manufacturer; and

(B) by striking subparagraph (B) and inserting the following:

“(B) exclusion of customary prompt pay discounts and other payments.—“(1) IN GENERAL.—The average manufacturer price for a covered outpatient drug shall exclude—

“(D) customary prompt pay discounts extended to wholesalers;

“(II) bona fide service fees paid by manufacturers to wholesalers or retail community pharmacies for goods and services related to distribution service fees, inventory management fees, product stocking allowances, and fees associated with administrative services agreements, with or without the use of electronic transmission systems (such as medication compliance programs and patient education programs);

“(III) reimbursement by manufacturers for recalls, returns, or other unsalable returned goods, including (but not limited to) reimbursement for the cost of the goods and any reimbursement of costs associated with return goods handling and processing, reverse logistics, and drug destruction; and

“(IV) payments received from, and rebates or discounts paid to, benefit managers, managed care organizations, health maintenance organizations, insurers, hospitals, clinics, mail order pharmacies, long-term care facilities, manufacturers, or any other entity that does not conduct business as a wholesaler or a retail pharmacy.

“(II) inclusion of other discounts and payments.—Notwithstanding clause (1), any other discounts, rebates, payments, or other financial transactions that are received by, paid by, generated through, or paid to, retail community pharmacies shall be included in the average manufacturer price for a covered outpatient drug.”; and

(c) in subparagraph (C), by striking “the retail pharmacy class of trade” and inserting “retail community pharmacies.”

(3) Definition of Multiple Source Drug.—

Section 1927(k)(7) of such Act (42 U.S.C. 1396r–8(k)(7)) is amended—

(A) in subparagraph (A)(I), by striking “‘other than a Medicare Part B pharmacy’” and inserting “‘the United States’”; and

(B) in subparagraph (C)—

(i) in clause (i), by inserting “and” after the semicolon;

(ii) in clause (ii), by striking “; and” and inserting a period; and

(iii) by striking clause (iii).

(4) Definitions of Retail Community Pharmacy, Wholesale.—Section 1927(k) of such Act (42 U.S.C. 1396r–8(k)) is amended by adding at the end the following new paragraphs: COMMUNITY PHARMACY.—The term ‘retail community pharmacy’ means an independent pharmacy, a supermarket pharmacy, a mass merchant-discount pharmacy, or a pharmacy managed by the State and that dispenses medications to the general public at retail prices. Such term does not include a pharmacy that dispenses medications to patients primarily through the mail, nursing home pharmacies, long-term care facility pharmacies, hospital pharmacies, clinics, summer camp pharmacies, managed care pharmacy benefit managers, or government pharmacies, or pharmacy benefit managers.

(II) Wholesaler.—The term ‘wholesaler’ means a drug wholesaler that is engaged in wholesale distribution of prescription drugs to retail community pharmacies, including (but not limited to) manufacturers, repackaging distributors, generic distributors, private-label distributors, jobbers, brokers, warehouses (including manufacturer’s and distributor’s warehouses, chain drug warehouses, and wholesale drug warehouses) independent wholesale drug traders, and retail community pharmacies that conduct wholesale distributions.”.

(b) Disclosure of Price Information to the Public.—Section 1927(b)(3) of such Act (42 U.S.C. 1396r–8(b)(3)) is amended—

(1) in subparagraph (A)—

(A) in the first sentence, by inserting after clause (ii) the following:

“(iv) not later than 30 days after the last day of each month of a rebate period under the agreement, on the manufacturer’s total number of rebate checks or other payments (in any form) to wholesalers for drugs distributed to retail community pharmacies; and

(B) by striking the second sentence, by inserting “or other entities that conduct business as a wholesaler or a retail pharmacy.

(2) Disclosure of Price Information to the Public.—Section 1927(b)(3) of such Act (42 U.S.C. 1396r–8(b)(3)) is amended—

(A) in the first sentence, by inserting “with respect to a retail community pharmacy;” before the “determination”; and

(B) in subparagraph (E)(v), by striking “average manufacturer prices” and inserting “the weighted average of the most recently reported monthly average manufacturer prices and the average retail survey price determined for each multiple source drug in accordance with subsection (f)”.

(c) Clarification of Application of Survey of Retail Prices.—Section 1927(f)(1) of such Act (42 U.S.C. 1396r–8(b)(1)) is amended—

(1) in subparagraph (A)(i), by inserting “with respect to a retail community pharmacy,” before “the determination”; and

(2) in subparagraph (B)(ii), by striking “retail pharmacies” and inserting “retail community pharmacies.”

(d) Effective Date.—The amendments made by this section shall take effect on the first day of the first calendar year quarter that begins at least 180 days after the date of enactment of this Act and exempt with respect to whether or not final regulations to carry out such amendments have been promulgated by such date.
SEC. 2551. DISPROPORTIONATE SHARE HOSPITAL PAYMENTS.

(a) In General.—Section 1923(f) of the Social Security Act (42 U.S.C. 1396c(f)) is amended—

(1) in paragraph (1), by striking “(3) and (B)” and inserting “(3), (B), and (C)”;

(2) in paragraph (2)(A), by striking “paragraph (6)” and inserting “paragraphs (6) and (7)”;

(3) by redesignating paragraph (7) as paragraph (8); and

(4) by inserting after paragraph (6) the following new paragraph:

“(7) REDUCTION OF STATE DSH ALLOTMENTS ONCE REDUCTION IN UNINSURED THRESHOLD REACHED.—

“(A) IN GENERAL.—Subject to subparagraph (E), the DSH allotment for a State for fiscal years beginning with the fiscal year described in subparagraph (C) (with respect to the State), is equal to—

“(i) in the case of the first fiscal year described in subparagraph (C) with respect to a State, the DSH allotment that would be determined under this paragraph for the State for the fiscal year without application of this paragraph (but after the application of subparagraph (F)), reduced by the applicable percentage determined for the State for the fiscal year under subparagraph (B)(i); and

“(ii) in the case of any subsequent fiscal year with respect to the State, the DSH allotment determined for the State for the preceding fiscal year, reduced by the applicable percentage determined for the State for the fiscal year under subparagraph (B)(i).

“(B) APPlicable PERCENTAGE.—For purposes of subparagraph (A), the applicable percentage for a State for a fiscal year is the following:

“(i) UNSURED REDUCTION THRESHOLD FISCAL YEAR.—In the case of the first fiscal year described in subparagraph (C) (with respect to the State)—

“(I) if the State is a low DSH State described in paragraph (5)(B), the applicable percentage is equal to 25 percent; and

“(II) if the State is any other State, the applicable percentage is 50 percent.

“(ii) SUBSEQUENT FISCAL YEARS IN WHICH THE PERCENTAGE OF UNINSURED DECREASES.—In the case of any fiscal year after the first fiscal year described in subparagraph (C) with respect to the State, the percentage determined under this paragraph for the State in accordance with this paragraph for the fiscal year from the preceding fiscal year to the fiscal year from the preceding fiscal year described in paragraph (5)(B), the applicable percentage is equal to the product of the percentage reduction in uncovered individuals for the fiscal year from the preceding fiscal year and 25 percent; and

“(II) if the State is any other State, the applicable percentage is equal to the product of the percentage reduction in uncovered individuals for the fiscal year from the preceding fiscal year and 50 percent.

“(C) FISCAL YEAR DESCRIBED.—For purposes of subparagraph (A), the fiscal year described in this subparagraph with respect to a State is the first fiscal year that occurs after fiscal year 2012 for which the Secretary determines, on the basis of the most recent American Community Survey of the Bureau of the Census, that the percentage of uncovered individuals residing in the State is at least 45 percent.

“(D) EXCLUSION OF PORTIONS DIVERTED FOR COVERAGE EXPANSIONS.—For purposes of applying the applicable percentage reduction under subparagraph (A) to the DSH allotment for a State that would be determined under this subsection for the State for the fiscal year without the application of this paragraph (other than any such reduction) shall not include any portion of the allotment for which the Secretary has approved the State’s diversion to the costs of providing medical assistance to other health benefits coverage under a waiver that is in effect on July 2009.

“(E) MINIMUM ALLOTMENT.—In no event shall the allotment determined for a State in accordance with this paragraph for fiscal year 2013 or any succeeding fiscal year be less than the amount equal to 35 percent of the DSH allotment determined for the State for fiscal year 2012 under this subsection (and after the application of this paragraph, if applicable), increased by the percentage change in the consumer price index for all urban consumers (all items, U.S. city average) for each previous fiscal year occurring before the fiscal year.

“(F) UNCOVERED INDIVIDUALS.—In this paragraph, the term ‘uncovered individuals’ means individuals with no health insurance coverage at any time during a year (as determined by the Secretary based on the most recent available data).”;

(b) EFFECTIVE DATE.—The amendments made by subsection (a) take effect on October 1, 2011.

Subtitle H—Improved Coordination for Dual Eligible Beneficiaries

SEC. 2001. 5-YEAR PERIOD FOR DEMONSTRATION PROGRAMS.

(a) In General.—Section 1915(h) of the Social Security Act (42 U.S.C. 1396n(h)) is amended—

(1) by inserting “(1)’’ after “(h)”;

(2) by inserting “, or a waiver described in paragraph (2)” after “(e)’’; and

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

“(2)(A) Notwithstanding subsections (c)(3) and (d), any waiver under subsection (b), (c), or (d), or a waiver under section 1115, that provides medical assistance for dual eligible individuals (including any such waivers under which non dual eligible individuals may be enrolled dual eligible individuals) may be conducted for a period of 5 years and, upon the request of the State, be extended for an additional 5-year periods unless the Secretary determines that for the previous waiver period the conditions for the waiver have not been met or it would no longer be cost-effective and efficient, or consistent with the purposes of this title, to extend the waiver.

“(B) In this paragraph, the term ‘dual eligible individual’ means an individual who is entitled to, or enrolled for, benefits under part A of title XVIII, or enrolled for benefits under part B of title XVIII, and is eligible for medical assistance under this title or under a waiver of such plan.

(b) CONFORMING AMENDMENTS.—

(1) Section 1915 of such Act (42 U.S.C. 1396n) is amended—

(A) in subsection (e)(2), by inserting “5 years, in the case of a waiver described in section 1915(h)(2)” after “Subsection”;

(B) in subsection (f)(6), by inserting “5 years, in the case of a waiver described in section 1915(h)(2)” after “3 years’’;

(2) Section 1115 of such Act (42 U.S.C. 1315) is amended—

(A) in subsection (e)(2), by inserting “5 years, in the case of a waiver described in section 1915(h)(2)” after “Subsection”;

(B) in subsection (f)(6), by inserting “5 years, in the case of a waiver described in section 1915(h)(2)” after “3 years’’.

SEC. 2002. PROVIDING FEDERAL COVERAGE AND PAYMENT COORDINATION FOR DUAL ELIGIBLE BENEFICIARIES.

(a) ESTABLISHMENT OF FEDERAL COORDINATED HEALTH CARE OFFICE.—

In general.—Not later than March 1, 2010, the Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall establish a Federal Coordinated Health Care Office to—

(1) establish an office of the Secretary and staff such office.

(b) ESTABLISHMENT AND REPORTING TO CMS ADMINISTRATOR.—The Federal Coordinated Health Care Office—

(A) shall be established within the Centers for Medicare & Medicaid Services; and

(B) have as the Office a Director who shall be appointed by, and be in direct line of authority to, the Administrator of the Centers for Medicare & Medicaid Services.

(b) PURPOSE.—The purpose of the Federal Coordinated Health Care Office is to bring together officers and employees of the Medicare and Medicaid programs in order to—

(1) increase the integration of benefits under the Medicare program, under title XVIII of the Social Security Act, and the Medicaid program under title XIX of such Act; and

(2) improve the coordination between the Federal Government and States for individuals eligible for benefits under both such programs in order to ensure that such individuals get full access to the benefits and services to which they are entitled under titles XVIII and XIX of the Social Security Act.

(c) GOALS.—The goals of the Federal Coordinated Health Care Office are as follows—

(1) Providing dual eligible individuals full access to the benefits to which such individuals are entitled under the Medicare and Medicaid programs.

(2) Simplifying the processes for dual eligible individuals to access the items and services they are entitled to under the Medicare and Medicaid programs.

(3) Improving the quality of health care and long-term services for dual eligible individuals.

(4) Increasing dual eligible individuals’ understanding of and satisfaction with coverage under the Medicare and Medicaid programs.

(5) Eliminating regulatory conflicts between rules under the Medicare and Medicaid programs.

(6) Improving care continuity and ensuring safe and effective care transitions for dual eligible individuals.

(7) Eliminating cost-shifting between the Medicare and Medicaid program and among related health care providers.

(8) Improving the quality of performance of providers of services and suppliers under the Medicare and Medicaid programs.

(d) SPECIFIC RESPONSIBILITIES.—The specific responsibilities of the Federal Coordinated Health Care Office are as follows:

(1) Providing States, specialized MA plans for special needs individuals (as defined in section 1915(b)(4)(B)(i) of the Social Security Act (42 U.S.C. 1396n(b)(4)(B)(i))), physicians and other relevant entities or individuals with the education and tools necessary for developing and implementing programs that expand the Medicare and Medicaid programs for dual eligible individuals.
(2) Supporting State efforts to coordinate and align acute care and long-term care services for dual eligible individuals with other items and services furnished under the Medicare program.

(3) Providing support for coordination of contracting and oversight by States and the Centers for Medicare & Medicaid Services with respect to the integration of the Medicare and Medicaid programs in a manner that is supportive of the goals described in paragraph (3).

(4) To establish and coordinate with the Medicare Payment Advisory Commission established under section 1805 of the Social Security Act (42 U.S.C. 1395b–6) and the Medicaid and CHIP Payment and Access Commission established under section 1900 of such Act (42 U.S.C. 1396w–12) with respect to the integration of the Medicare and Medicaid programs in a manner that is supportive of the goals described in paragraph (3).

(5) To study the provision of drug coverage for new full-benefit dual eligible individuals (as defined in section 1935(o)(6) of the Social Security Act (42 U.S.C. 1395ww(d)(4)(D)(iv)), as to monitor and report annual total expenditures, health outcomes, and access to benefits for all dual eligible individuals.

(f) DUAL ELIGIBLE DEFINED.—In this section, the term ‘‘dual eligible individual’’ means an individual who is entitled to, or enrolled for, benefits under part A of title X of the Social Security Act (42 U.S.C. 1395ww(d)(4)(D)(ii)) for such benefits under part B of title XVIII of such Act, and is eligible for medical assistance under a State plan under title XIX of such Act or under a waiver of such plan.

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

SEC. 2701. ADULT HEALTH QUALITY MEASURES.

Title XI of the Social Security Act (42 U.S.C. 1396 et seq.), as amended by section 401 of the Children’s Health Insurance Program Reauthorization Act of 2009 (Public Law 111–3), is amended by inserting after section 1109a the following new section:

SEC. 1109b. ADULT HEALTH QUALITY MEASURES.

(a) DEVELOPMENT OF CORE SET OF HEALTH CARE QUALITY MEASURES FOR ADULTS ELIGIBLE FOR BENEFITS UNDER MEDICAID.—The Secretary shall identify and publish a recommended core set of adult health quality measures for Medicaid eligible adults in the same manner as the Secretary identifies and publishes a core set of child health quality measures under section 1109a, including with respect to the development, testing, and publication of adult health quality measures that are in use under public and privately sponsored health care coverage arrangements, or that are part of the health care system, that are based on the presence and duration of health insurance coverage over time, that may be applicable to Medicaid eligible adults.

(b) DUAL ELIGIBLE DEFINED.—In this section, the term ‘‘dual eligible individual’’ means an individual who is entitled to, or enrolled for, benefits under part A of title X of the Social Security Act (42 U.S.C. 1395ww(d)(4)(D)(ii)) for such benefits under part B of title XVIII of such Act, and is eligible for medical assistance under a State plan under title XIX of such Act or under a waiver of such plan.

Title II—Improving Payment for Services Provided to Medicaid and CHIP Eligible Individuals

SEC. 2702. PAYMENT ADJUSTMENT FOR HEALTH CARE-ACQUIRED CONDITIONS.

(a) IN GENERAL.—The Secretary of Health and Human Services in this subsection referred to as the ‘‘Secretary’’ shall identify current State practices that prohibit payment for health care-acquired conditions and shall incorporate the practices identified, or elements of such practices, which the Secretary determines are consistent with the implementation of the Medicaid program in regulations. Such regulations shall be effective as of July 1, 2011, and shall prohibit payments to States that, on or after October 1, 2010, provide a waiver in order to implement this section for any amounts expended for medical assistance for health care-acquired conditions specified in the regulations. The regulations shall ensure that the prohibition on payment for health care-acquired conditions shall not result in a loss of access to care or services for Medicaid beneficiaries.

(c) MEDICARE PROVISIONS.—In exercising authority under this section, the Secretary shall apply to State plans (or waivers) under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) the provisions promulgated pursuant to section 1136(a)(2) of such Act (42 U.S.C. 1396ww(d)(4)(D)) relating to the prohibition of payments based on the presence of a secondary diagnosis specified by the Secretary in such regulations, as appropriate for the Medicaid program. The Secretary may exclude certain conditions identified under title XIX of the Social Security Act for non-payment under title XIX of such Act when the Secretary finds the inclusion of such conditions to be inappropriate for the purposes of such title.

SEC. 2703. STATE OPTION TO PROVIDE HOME AND COMMUNITY-BASED SERVICES FOR INDIVIDUALS WITH CHRONIC CONDITIONS.

(a) STATE PLAN AMENDMENT.—Title XIX of the Social Security Act (42 U.S.C. 1396a et seq.), as amended by sections 2201 and 2305, is amended by adding at the end the following new section:

‘‘SEC. 1945. STATE OPTION TO PROVIDE COORDINATED CARE THROUGH A HEALTH HOME FOR INDIVIDUALS WITH CHRONIC CONDITIONS.—

‘‘(a) IN GENERAL.—Notwithstanding section 1902(a)(1) (relating to state plans), section 1902(a)(10)(B) (relating to comparability), and section 1902(a)(14) (relating to which the Secretary determines it is necessary to waive in order to implement this section, beginning January 1, 2011, a State, at its option as part of a State plan amendment, may provide for medical assistance under this title to eligible individuals with chronic conditions who select a designated provider (as described under subsection (b)(5)), a team of health care professionals (as described under subsection (b)(6)) operating with such a provider, or a health team with payment for the provision of health care services to each eligible individual with chronic conditions who select such provider, team of health care professionals, or health team as the individual’s health home. Payments made to a designated provider, a team of health care professionals, or a health team for such services shall be treated as medical assistance for purposes of
section 1903(a), except that, during the first 8 fiscal year quarters that the State plan amendment is in effect, the Federal medical assistance percentage applicable to such payments shall be 70 percent.

(2) METHODOLOGY.—

(A) IN GENERAL.—The State shall specify in the State plan amendment the methodology the State will use for determining payment for the provision of health home services. Such methodology for determining payment—

(i) may be tiered, with respect to each eligible individual with chronic conditions provided such services by a designated provider, a team of health care professionals, or a health team, as well as the severity or number of each such individual’s chronic conditions or the specific capabilities of the provider, team of health care professionals, or health team; and

(ii) shall be established consistent with section 1902(a)(30)(A).

(B) ALTERNATE MODELS OF PAYMENT.—The methodology for determining payment for provision of health home services under this section shall not be limited to a per-member per-month methodology, but may provide for the use of a per diem, case rate, or fee-for-service methodology for determining payment for the provision of health home services. The methodology for determining payment—

(i) may be tiered, with respect to each eligible individual with chronic conditions provided such services by a designated provider, a team of health care professionals, or a health team, as well as the severity or number of each such individual’s chronic conditions or the specific capabilities of the provider, team of health care professionals, or health team; and

(ii) shall be established consistent with section 1902(a)(30)(A).

(C) LIMITATION.—The total amount of payments made to States under this paragraph shall not exceed $29,000,000.

(D) HOSPITAL REFERRALS.—A State shall include in the State plan amendment a requirement for hospitals that are participating providers under the State plan or a waiver of such plan to establish procedures for referring any eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated providers.

(E) COORDINATION.—A State shall consult and coordinate, as appropriate, with the Substance Abuse and Mental Health Services Administration in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.

(f) MONITORING.—A State shall include in the State plan amendment—

(1) a methodology for tracking avoidable hospital readmissions and calculating savings that result from improved chronic care coordination, administration, and management under this section; and

(2) a proposal for use of health information technology in providing health home services within this section and improving service delivery and coordination across the care continuum (including the use of wire- less patient technology to improve coordination and adherence to recommendations made by their provider).

(g) REPORT ON QUALITY MEASURES.—As a condition for receiving payment for health home services provided to an eligible individual with chronic conditions, a designated provider under the State, and any entity operating with such provider, shall ensure the following:

(1) a system and infrastructure in place to collect data on key health care services; and

(2) a process for using the data collected in (1) to assess and improve the provision of care, and to ensure this information is linked to services, as feasible and appropriate.

(h) DESIGNATED PROVIDER.—(1) The term ‘designated provider’ means a physician, clinical practice or group practice, rural clinic, community health center, community mental health center, home health agency, or any other entity or provider (including peer therapists) that is determined by the State and approved by the Secretary to be a health home for eligible individuals with chronic conditions. The term ‘designated provider’ also means a physician, clinical practice or group practice, rural clinic, community health center, community mental health center, home health agency, or any other entity or provider (including peer therapists) that is determined by the State and approved by the Secretary to be an eligible provider under section 1903(a), except that the term ‘designated provider’ under that section includes any entity that provides health services to a health team selected by an eligible individual with chronic conditions.

(2) The term ‘designated provider’ means a physician, clinical practice or group practice, rural clinic, community health center, community mental health center, home health agency, or any other entity or provider (including peer therapists) that is determined by the State and approved by the Secretary to be a health home for eligible individuals with chronic conditions. The term ‘designated provider’ also means a physician, clinical practice or group practice, rural clinic, community health center, community mental health center, home health agency, or any other entity or provider (including peer therapists) that is determined by the State and approved by the Secretary to be an eligible provider under section 1903(a), except that the term ‘designated provider’ under that section includes any entity that provides health services to an eligible individual with chronic conditions. The term ‘designated provider’ also means a physician, clinical practice or group practice, rural clinic, community health center, community mental health center, home health agency, or any other entity or provider (including peer therapists) that is determined by the State and approved by the Secretary to be an eligible provider under section 1903(a), except that the term ‘designated provider’ under that section includes any entity that provides health services to an eligible individual with chronic conditions.

(i) DEFINITIONS.—In this section:

(1) ELIGIBLE INDIVIDUAL WITH CHRONIC CONDITIONS.—

(A) IN GENERAL.—Subject to subparagraphs (B) and (C), the term ‘eligible individual with chronic conditions’ means an individual who—

(i) is eligible for medical assistance under the State plan or under a waiver of such plan; and

(ii) has at least—

(I) 2 chronic conditions; or

(ii) chronic condition and is at risk of having a second chronic condition; or

(III) 1 serious and persistent mental health condition.

(B) RULE OF CONSTRUCTION.—Nothing in this paragraph shall prevent the Secretary from establishing higher levels as to the severity of or number of chronic conditions provided such services by a designated provider, a team of health care professionals, or a health team.

(C) DESIGNATED PROVIDER.—The term ‘designated provider’ means a designated provider that operates in coordination with a health team selected by an eligible individual with chronic conditions.

(D) HOSPITAL REFERRALS.—A State shall—

(i) include physicians and other professionals, such as a nurse care coordinator, nutritionist, social worker, mental health professional, or any other professionals deemed appropriate by the State; and

(ii) be free standing, virtual, or based at a health home for an eligible individual with chronic conditions.

(E) Heart disease.

(F) Diabetes.

(G) Asthma.

(H) Substance use disorder.

(i) Hospital admissions.

(j) Chronic disease management.

(k) Coordination of care for individuals with chronic conditions.

(l) Assessment of program implementation.

(m) Processes and lessons learned.

(n) Assessment of quality improvements and clinical outcomes under this option.

(o) Estimates of cost savings.

(B) IMPLEMENTATION REPORTING.—A State that has elected the option under section 1945 of the Social Security Act (as added by subsection (a)) for the purpose of determining the effect of such option on reducing hospital admissions, emergency room visits, and admissions to skilled nursing facilities.

(C) EVALUATION REPORT.—Not later than January 1, 2017, the Secretary shall report to Congress on the nature, extent, and impact of such option, particularly as it pertains to—

(i) hospital admission rates;

(ii) chronic disease management;

(iii) coordination of care for individuals with chronic conditions;

(iv) assessment of program implementation;

(v) processes and lessons learned (as described in subparagraph (B));

(vi) assessment of quality improvements and clinical outcomes under this option;

(vii) estimates of cost savings.

(B) IMPLEMENTATION REPORTING.—A State that has elected the option under section 1945 of the Social Security Act (as added by subsection (a)) shall report to the Secretary, as necessary, on processes that have been developed and lessons learned regarding provision of coordinated care through a health home for Medicaid beneficiaries with chronic conditions under such option.

SEC. 2704. DEMONSTRATION PROJECT TO EVALUATE INTEGRATED CARE AROUND A HOSPITALIZATION.

(a) AUTHORITY TO CONDUCT PROJECT.—

(1) IN GENERAL.—The Secretary of Health and Human Services (hereafter referred to as the ‘‘Secretary’’) shall establish a demonstration project under title XIX of the Social Security Act to evaluate the use of bundled payments for the provision of integrated care for a Medicaid beneficiary—

(i) with respect to an episode of care that includes a hospitalization; and

(ii) for concurrent or bundled services provided during a hospitalization.

(2) DURATION.—The demonstration project shall begin on January 1, 2012, and shall end on December 31, 2016.

(b) REQUIREMENTS.—The demonstration project shall be conducted in accordance with the following:

(1) The demonstration project shall be conducted in up to 8 States, determined by the...
the Secretary shall submit a report to Congress on the demonstration project.

SEC. 2705. MEDICAID GLOBAL PAYMENT SYSTEM DEMONSTRATION PROJECT.

(a) In General.—The Secretary of Health and Human Services (referred to in this section as the ‘‘Secretary’’) shall, in coordination with the State for the Medicare and Medicaid program under section 1115A of the Social Security Act, as added by section 3021 of this Act, establish the Medicaid Global Payment System Demonstration Project. Such participating State shall adjust the payments made to an eligible safety net hospital system or network from a fee-for-service payment structure to a global capped payment model.

(b) Duration and Scope.—The demonstration project conducted under this section shall operate during a period of fiscal years 2010 through 2012. The Secretary shall select not more than 5 States to participate in the demonstration project.

(c) Eligible Safety Net Hospital System or Network.—For purposes of this section, the term ‘‘eligible safety net hospital system or network’’ means an eligible safety net hospital system or network (as defined by the Secretary) that operates within a State selected by the Secretary under subsection (b).

(d) Evaluation and Report.—

(1) Testing.—The Innovation Center shall test and evaluate the demonstration project conducted under this section to examine any changes in episodes and expenditures under this section (c), and provide for a determination of whether changes in episodes and expenditures relate to any changes in utilization, quality, or cost.

(2) Budget Neutrality.—During the testing period under paragraph (1), any budget neutrality requirements under section 1115A(b)(3) of the Social Security Act (as so added) shall not be applicable.

(3) Modification.—During the testing period under paragraph (1), the Secretary may, in the Secretary’s discretion, modify or terminate the demonstration project conducted under this section.

(e) Requirement for Appropriations.—There are authorized to be appropriated such sums as are necessary to carry out this section.

SEC. 2707. MEDICAID EMERGENCY PSYCHIATRIC DEMONSTRATION PROJECT.

(a) Authority To Conduct Demonstration Project.—The Secretary of Health and Human Services (in this section referred to as the ‘‘Secretary’’) shall establish a demonstration project under which an eligible State (as described in subsection (c)) shall conduct an accountable care organization (as defined under section 1115A(a)(3) of the Social Security Act (as added by section 3021 of this Act)) that is subject to the requirements of section 1867 of the Social Security Act (42 U.S.C. 1395ddd) for the provision of medical assistance available under such plan to individuals who meet specified requirements (as described in subsection (d)).

(b) Limitation on Appropriations.—There are authorized to be appropriated such sums as are necessary to carry out this section.

SEC. 2708. PEDIATRIC ACCOUNTABLE CARE ORGANIZATION DEMONSTRATION PROJECT.

(a) Authority to Conduct Demonstration Project.—

(1) In General.—The Secretary of Health and Human Services (referred to in this section as the ‘‘Secretary’’) shall establish the Pediatric Accountable Care Organization Demonstration Project to authorize a participating State to allow pediatric medical providers that meet specified requirements to organizations that meet specified requirements to become accountable care organizations for purposes of receiving incentive payments (as described in subsection (d)), to carry out the requirements of this section (1867 of the Social Security Act (42 U.S.C. 1395ddd) for the provision of medical assistance available under such plan to individuals who meet specified requirements (as described in subsection (d)).

(2) Requirement for Appropriations.—There are authorized to be appropriated such sums as are necessary to carry out this section.
(E) A recommendation regarding whether the demonstration project should be continued after December 31, 2013, and expanded on a national basis.

(2) The Secretary shall submit to Congress and make available to the public a report on the findings of the evaluation under paragraph (1).

(g) **Waiver Authority.**—

(1) **In General.**—The Secretary shall waive the limitation of subdivision (B) following paragraphs (1902(a)(1) of the Social Security Act (42 U.S.C. 1396d(a)) (relating to limitations on payments for care or services for individuals under 65 years of age who are patients in an institution for mental diseases) for purposes of carrying out the demonstration project under this section.

(2) **Limited Other Waiver Authority.**—The Secretary may waive other requirements of titles XI and XIX of the Social Security Act (including the requirements of sections 1902(a)(1) (relating to statewideness) and 1902(a)(10) (relating to comparability)) only to extent necessary to carry out the demonstration project under this section.

(h) **Definitions.**—In this section:

(1) **Emergency Condition.**—The term “emergency medical condition” means, with respect to an individual, an individual who expresses suicidal or homicidal thoughts or gestures, if determined dangerous to self or others.

(2) **Federal Medical Assistance Percentage.**—The term “Federal medical assistance percentage” has the meaning given to that term in section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)).

(3) **Institution for Mental Diseases.**—The term “institution for mental diseases” has the meaning given to that term in section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)).

(4) **Medical Assistance.**—The term “medical assistance” has the meaning given that term in section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)).

(5) **Stabilized.**—The term “stabilized” means, with respect to an individual, that the emergency medical condition no longer exists with respect to the individual and the individual is no longer dangerous to self or others.

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

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

SEC. 2801. **MACPAC Assessment of Policies Affecting All Medicaid Beneficiaries.**

(a) **In General.**—Section 1900 of the Social Security Act (42 U.S.C. 1396) is amended—

(1) in paragraph (1)—

(A) in such paragraph, by striking “FOR ALL STATES” before “AND ANNUAL”;

(B) by striking “(I), (II), (III), and (IV)” after “(III)”; and

(C) by adding the following:

“(V) a description of all such areas or problems that adversely affect, or have the potential to adversely affect, access to care by, or the quality of care available to, Medicaid and CHIP beneficiaries.

MACPAC shall include in the annual report required under paragraph (1)(D) a description of all such areas or problems that adversely affect, or have the potential to adversely affect, access to care by, or the quality of care available to, Medicaid and CHIP beneficiaries.

B) review national and State-specific Medicaid and CHIP data; and

(C) submit reports and recommendations to Congress, the Secretary, and States based on such reviews.

(E) in paragraph (4), as redesignated by subparagraph (C), by striking “or any other problems” and all that follows through the period and inserting “, as well as other factors that adversely affect, or have the potential to adversely affect, access to care by, or the quality of care available to, Medicaid and CHIP beneficiaries.

MACPAC shall include in the annual report required under paragraph (1)(D) a description of all such areas or problems that adversely affect, or have the potential to adversely affect, access to care by, or the quality of care available to, Medicaid and CHIP beneficiaries.

(F) in paragraph (5), as so redesignated,
In the paragraph heading, by inserting “AND REGULATIONS” after “REPORTS”; and
(ii) by striking “I” and inserting the following:

(A) CERTAIN SECRETARIAL REPORTS.—I;
and
(iii) in the second sentence, by inserting “and the Secretary” after “appropriate committees” and
(iv) by adding at the end the following:

(B) REGULATIONS.—MACPAC shall review Medicaid and CHIP regulations and may conduct through submission of a report to the appropriate committees of Congress and the Secretary, on any such regulations that affect access, quality, or efficiency of health care.

In paragraph (19), as so redesignated, by inserting “, and shall submit with any recommendations, a report on the Federal and State-specific budget consequences of the recommendations” before the period; and

(H) by adding at the end the following:

(II) CONSULTATION AND COORDINATION WITH MEDPAC:

(A) IN GENERAL.—MACPAC shall consult with the Medicare Payment Advisory Commission (in this paragraph referred to as ‘‘MedPAC’’) established under section 1905 in carrying out its duties under this section, as appropriate and particularly with respect to the issues specified in paragraph (2) as they relate to Medicaid and CHIP beneficiaries who are dually eligible for Medicaid and the Medicare program under title XVIII, adult Medicare beneficiaries (who are not dually eligible for Medicare and benefits under Medicare). Responsibility for analysis of and recommendations to change Medicare policy regarding Medicare beneficiaries, including Medicaid beneficiaries who are dually eligible for Medicare and Medicaid, shall rest with MedPAC.

(B) INFORMATION SHARING.—MedPAC shall have access to deliberations and records of the other such entity, respectively, upon the request of the other such entity.

(II) CONSULTATION WITH STATES.—MACPAC shall regularly consult with States in carrying out its duties under this section, including with respect to developing processes and procedures for such duties, and shall ensure that input from States is taken into account and represented in MACPAC’s recommendations and reports.

(III) COORDINATE CONSULT WITH THE FEDERAL COORDINATED HEALTH CARE OFFICE.—

MACPAC shall coordinate and consult with the Federal Coordinated Health Care Office established under section 1880(e)(1)(A) of the Social Security Act (42 U.S.C. 1395w(e)(1)(A)) to the extent feasible, before the period; and

(III) by adding at the end the following:

(O) FUNDING FOR FISCAL YEAR 2010.—

(A) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Commission for its fiscal year 2010, $9,000,000.

(B) TRANSFER OF FUNDS.—Notwithstanding section 2104(a)(13), from the amounts appropriated in such section for fiscal year 2010, $2,000,000 is hereby transferred to the Federal Coordinated Health Care Office established under section 1880(e)(1)(A) of the Social Security Act (42 U.S.C. 1395w(e)(1)(A)) to the extent feasible, before the period; and

(IV) AVAILABILITY.—Amounts made available under paragraphs (2) and (3) to MACPAC to carry out the provisions of this section shall remain available until expended.

(IV) AMENDMENTS.—Section 1855b of the Social Security Act (42 U.S.C. 1395v(b)), is amended—

(1) in paragraph (1)(C), by inserting “March 1 of each fiscal year” before “and March 1”; and

(2) in paragraph (1)(D), by inserting “, and (beginning with 2012) containing an examination of the trend towards the extent feasible” before the period; and

(3) by adding at the end the following:

(9) REVIEW AND ANNUAL REPORT ON MEDICAID AND CHIP ACOs.—The Commission shall review and report on aggregate trends in spending, utilization, and financial performance under the Medicaid and CHIP programs for fiscal year 2010.

(V) AMENDMENTS.—Section 1855b of the Social Security Act (42 U.S.C. 1395v(b)), is amended—

(1) in the clause heading, by inserting “AND INDIAN TRIBES AND TRIBAL ORGANIZATIONS” after “AGENCIES”; and

(2) by adding at the end the following:

(IV) TO INDIVIDUALS.—The amendment made by this section shall apply to services furnished on or after January 1, 2010.

Subtitle L—Maternal and Child Health Services

SEC. 2902. ELIMINATION OF SUNSET FOR REIMBURSEMENT FOR ALL MEDICARE PART B SERVICES FURNISHED BY CERTAIN INDIAN HOSPITALS AND CLINICS.

(a) REIMBURSEMENT FOR ALL MEDICARE PART B SERVICES FURNISHED BY CERTAIN INDIAN HOSPITALS AND CLINICS.—Section 1833(e)(1)(A) of the Social Security Act (42 U.S.C. 1395ww(e)(1)(A)) is amended by striking “under (I) the five-year period ending on” and inserting “(i) the five-year period ending on”.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2010.

Subtitle M—Maternal and Child Health Services

SEC. 2905. MATERNAL, INFANT, AND EARLY CHILDHOOD HOME VISITING PROGRAMS.

Title V of the Social Security Act (42 U.S.C. 501 et seq.) is amended by adding at the end the following new section:

SEC. 511. MATERNAL, INFANT, AND EARLY CHILDHOOD HOME VISITING PROGRAMS.

(a) PURPOSES.—The purposes of this section are—

(1) to strengthen and improve the programs and activities carried out under this title;
(2) to improve coordination of services for at-risk communities; and
(3) to identify and provide comprehensive services to improve outcomes for families who reside in at-risk communities.

(b) REQUIREMENT FOR THE SECRETARY TO ASSESS STATEWIDE NEEDS AND IDENTIFY AT RISK COMMUNITIES.
“(1) IN GENERAL.—Not later than 6 months after the date of enactment of this section, each State shall, as a condition of receiving payments from an allotment for the State under this section, coordinate, in fiscal year 2011, a statewide needs assessment (which shall be separate from the statewide needs assessment required under section 506(a)) that identifies—

(A) communities with concentrations of—

(i) premature birth, low-birth weight infants, and infant mortality, including infant death rates to the extent available indicators of at-risk prenatal, maternal, newborn, or child health;

(ii) poverty;

(iii) crime;

(iv) domestic violence;

(v) high rates of high-school drop-outs;

(vi) substance abuse;

(vii) unemployment; or

(viii) child maltreatment; and

(B) the quality and capacity of existing programs or initiatives for early childhood home visitation in the State including—

(i) the number and types of individuals and families who are receiving services under such programs or initiatives;

(ii) rates in the number of early childhood home visitation in the State; and

(iii) the extent to which such programs or initiatives are meeting the needs of eligible families described in subsection (k) of section 101. This assessment shall be developed and implemented in collaboration with the community, the Secretary, State and local agencies, and nonprofit organizations.

(C) the State’s capacity for providing substance abuse treatment and counseling services to individuals and families in need of such treatment or services.

(2) COORDINATION WITH OTHER ASSESSMENTS.—In conducting the statewide needs assessment required under paragraph (1), the State shall coordinate with, and take into account, other appropriate needs assessments conducted by the State, as determined by the Secretary, including the needs assessment conducted under section 502 for fiscal year 2011, conduct a statewide needs assessment (which shall be separate from the statewide needs assessment and shall be conducted by the Secretary). Such assessment shall include the areas specified in paragraph (1)(A), and shall be completed by the Secretary on or before September 30, 2012, to meet the requirements of subsection (d) to eligible entities.

(3) SUBMISSION TO THE SECRETARY.—Each State shall submit to the Secretary, in such form and manner as the Secretary shall require—

(A) the results of the statewide needs assessment required under paragraph (1); and

(B) a description of how the State intends to address needs identified by the assessment, particularly with respect to communities identified under paragraph (1)(A), which may include, as appropriate for a grantee to conduct an early childhood home visitation program in accordance with the requirements of this section.

(4) AUTHORITY TO MAKE GRANTS.—In addition to any other payments made under this title to a State, the Secretary shall make grants to eligible entities to develop and implement an early childhood home visitation program that satisfies the requirements of subsection (d) to eligible families, consistent with State child welfare policies, in order to promote improvements in maternal and prenatal health, infant health, child health and development, parent-related to child development outcomes, the economic status of such families, and reductions in child abuse, neglect, and injuries.

(5) AUTHORITY TO USE INITIAL GRANT FUNDS FOR PLANNING OR IMPLEMENTATION.—An eligible entity that receives a grant under paragraph (4) may use any portion of the funds awarded to the entity during the first 6 months of the period for which the grant is made for planning or implementation activities to assist with the establishment of early childhood home visitation programs that satisfy the requirements of subsection (d).

(6) GRANT DURATION.—The Secretary shall determine the period of years for which a grant is made to an eligible entity under paragraph (1).

(7) TECHNICAL ASSISTANCE.—The Secretary shall provide grant recipients that receive a grant under paragraph (1) with technical assistance in administering programs or activities conducted in whole or in part with grant funds that assist with the establishment of early childhood home visitation programs in each of the following areas:

(a) Improved maternal and newborn health;

(b) Prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits;

(c) Improvement in school readiness and achievement;

(d) Reduction in crime or domestic violence;

(e) Improvements in family economic self-sufficiency;

(f) Improvements in the coordination and referrals for other community resources and supports;

(g) DEMONSTRATION OF IMPROVEMENTS AFTER 3 YEARS.—

(i) REPORT TO THE SECRETARY.—Not later than 30 days after the end of the 3rd year in which the entity conducts the program, the entity submits to the Secretary a report demonstrating improvement in at least 4 of the areas specified in subparagraph (A).

(ii) PROOF OF IMPROVEMENT.—If the report submitted under clause (i) fails to demonstrate improvement in at least 4 of the areas specified in subparagraph (A), the entity shall submit to the Secretary a report demonstrating improvement in each of the areas specified in subparagraph (A), subject to approval by the Secretary. The plan to improve outcomes shall be consistent with the requirements of section 506(a) for each of the areas specified in subparagraph (A).

(iii) PROOF OF IMPROVEMENT.—If the plan submitted under clause (ii) fails to demonstrate improvement in at least 4 of the areas specified in subparagraph (A), the entity shall submit to the Secretary a report demonstrating improvement in at least 4 of the areas specified in subparagraph (A), subject to approval by the Secretary. The plan to improve outcomes shall be consistent with the requirements of section 506(a) for each of the areas specified in subparagraph (A).

(iv) TECHNICAL ASSISTANCE.—The Secretary shall provide the entity with technical assistance in administering programs or activities conducted in whole or in part with grant funds that assist with the establishment of early childhood home visitation programs in each of the following areas:

(a) Improved maternal and newborn health;

(b) Prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits;

(c) Improvement in school readiness and achievement;

(d) Reduction in crime or domestic violence;

(e) Improvements in family economic self-sufficiency;

(f) Improvements in the coordination and referrals for other community resources and supports;

(g) DEMONSTRATION OF IMPROVEMENTS AFTER 3 YEARS.—

(i) REPORT TO THE SECRETARY.—Not later than 30 days after the end of the 3rd year in which the entity conducts the program, the entity submits to the Secretary a report demonstrating improvement in at least 4 of the areas specified in subparagraph (A).

(ii) PROOF OF IMPROVEMENT.—If the report submitted under clause (i) fails to demonstrate improvement in at least 4 of the areas specified in subparagraph (A), the entity shall submit to the Secretary a report demonstrating improvement in each of the areas specified in subparagraph (A), subject to approval by the Secretary. The plan to improve outcomes shall be consistent with the requirements of section 506(a) for each of the areas specified in subparagraph (A).

(iii) PROOF OF IMPROVEMENT.—If the plan submitted under clause (ii) fails to demonstrate improvement in at least 4 of the areas specified in subparagraph (A), the entity shall submit to the Secretary a report demonstrating improvement in each of the areas specified in subparagraph (A), subject to approval by the Secretary. The plan to improve outcomes shall be consistent with the requirements of section 506(a) for each of the areas specified in subparagraph (A).

(iv) TECHNICAL ASSISTANCE.—The Secretary shall provide the entity with technical assistance in administering programs or activities conducted in whole or in part with grant funds that assist with the establishment of early childhood home visitation programs in each of the following areas:

(a) Improved maternal and newborn health;

(b) Prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits;

(c) Improvement in school readiness and achievement;

(d) Reduction in crime or domestic violence;

(e) Improvements in family economic self-sufficiency;

(f) Improvements in the coordination and referrals for other community resources and supports;

(g) DEMONSTRATION OF IMPROVEMENTS AFTER 3 YEARS.—

(i) REPORT TO THE SECRETARY.—Not later than 30 days after the end of the 3rd year in which the entity conducts the program, the entity submits to the Secretary a report demonstrating improvement in at least 4 of the areas specified in subparagraph (A).

(ii) PROOF OF IMPROVEMENT.—If the report submitted under clause (i) fails to demonstrate improvement in at least 4 of the areas specified in subparagraph (A), the entity shall submit to the Secretary a report demonstrating improvement in each of the areas specified in subparagraph (A), subject to approval by the Secretary. The plan to improve outcomes shall be consistent with the requirements of section 506(a) for each of the areas specified in subparagraph (A).

(iii) PROOF OF IMPROVEMENT.—If the plan submitted under clause (ii) fails to demonstrate improvement in at least 4 of the areas specified in subparagraph (A), the entity shall submit to the Secretary a report demonstrating improvement in each of the areas specified in subparagraph (A), subject to approval by the Secretary. The plan to improve outcomes shall be consistent with the requirements of section 506(a) for each of the areas specified in subparagraph (A).

(iv) TECHNICAL ASSISTANCE.—The Secretary shall provide the entity with technical assistance in administering programs or activities conducted in whole or in part with grant funds that assist with the establishment of early childhood home visitation programs in each of the following areas:
shall use not more than 25 percent of the amount of the grant paid to the entity for a fiscal year for purposes of conducting a program using the service delivery model described in subsection (d)(3)(A).

"(ii) The program maintains high quality supervision to establish home visitor competency.

"(iii) The program monitors the fidelity of program implementation to ensure that services are delivered pursuant to the specified model.

"(4) AUTHORITY TO CONDUCT EVALUATION.—(A) The Secretary may require, that includes the following:

"(i) conduct a needs assessment similar to the assessment required for all States under subsection (b)(1)(A), and the grants made available from allotments under subsection (b); and

"(ii) the awarding and oversight of grants awarded under this section, the establishment of the advisory panels required under subsections (d)(1)(B)(iii) and (g)(1), and the evaluation and report required under subsection (g); and

"(B) maintaining and advising the Secretary regarding the progress of the evaluation; and

"(C) to comment, if the panel so desires, on the report submitted under paragraph (3).

"(2) AUTHORITY TO CONDUCT EVALUATION.—On the basis of the recommendations of the independent advisory panel under paragraph (1), the Secretary shall, by grant, contract, or interagency agreement, conduct an evaluation of the statewide needs assessment conducted under subsection (b) and the grants made available from allotments under subsections (c) and (h)(3)(B). The evaluation shall include:

"(A) an analysis, on a State-by-State basis, of the results of such assessments, including indicators of maternal and prenatal health and infant health and mortality, and State actions in response to such assessments; and

"(B) an assessment of—

"(i) the effect of early childhood home visitation programs on child and parent outcomes, including the extent to which the ability of programs to improve participant outcomes varies across programs and populations; and

"(ii) the potential for the activities conducted under such programs, if scaled broadly, to improve health and social outcomes, eliminate health disparities, and improve health care system quality, efficiencies, and reduce costs.

"(3) REPORT.—Not later than March 31, 2015, the Secretary shall submit a report to Congress on the results of the evaluation conducted under paragraph (2) and shall make the report publicly available.

"(4) OTHER PROVISIONS.—(1) INTRA-AGENCY COLLABORATION.—The Secretary shall ensure that the Head Start Bureau and the Administration for Children and Families collaborate with respect to carrying out this section, including with respect to:

"(A) reviewing and analyzing the statewide needs assessments required under subsection (b), the awarding and oversight of grants awarded under this section, the establishment of the advisory panels required under subsections (d)(1)(B)(iii) and (g)(1), and the evaluation and report required under subsection (g); and

"(B) consulting with other Federal agencies with responsibility for administering or evaluating programs that serve eligible families to coordinate and collaborate with respect to research related to such programs and families, including the Office of the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services, the Centers for Disease Control and Prevention, the National Institute of Child Health and Human Development, the National Institutes of Health, the Office of Juvenile Justice and Delinquency Prevention of the Department of Justice, and the Institute of Education Sciences of the Department of Education.

"(2) GRANTS TO ELIGIBLE ENTITIES THAT ARE NOT STATES.—(A) INDIAN TRIBES, TRIBAL ORGANIZATIONS, OR URBAN INDIAN ORGANIZATIONS.—The Secretary shall specify requirements for eligible entities that are Indian Tribes (or a consortium of Indian Tribes), Tribal Organizations, or Urban Indian Organizations to apply for and conduct an early childhood home visitation program with a grant under this section. Such requirements shall be the greatest extent practicable, be consistent with the requirements applicable to eligible entities that are States and shall require an Indian Tribe (or consortium), Tribal Organization, or Urban Indian Organization to—

"(i) conduct a needs assessment similar to the assessment required for all States under subsection (b); and

"(ii) establish quantifiable, measurable 3- and 5-year benchmarks consistent with the requirements applicable to States under subsection (b).
to make a grant to an eligible entity that is a nonprofit organization described in subsection (k)(1)(B) to conduct an early childhood home visiting program in the State. The Secretary shall specify the requirements for such an organization to apply for and conduct the program which shall, to the greatest extent practicable, be consistent with the standards applicable to eligible entities that are States and shall require the organization to—

(1) carry out the program based on the needs assessment conducted by the State under subsection (b); and

(2) establish quantifiable, measurable 3- and 5-year benchmarks consistent with subsection (d)(1)(A).

(3) Research and Other Evaluation Activities.

(A) In General.—The Secretary shall carry out a continuous program of research and evaluation activities in order to increase knowledge about the implementation and effectiveness of home visiting programs, using random assignment designs to the maximum extent feasible. The Secretary may carry out such activities directly, or through grants, cooperative agreements, or contracts.

(B) Requirements.—The Secretary shall ensure that—

(i) evaluation of a specific program or project is conducted by persons or individuals not directly involved in the operation of such program or project; and

(ii) such research and evaluation activities includes consultation with independent researchers, State officials, and developers and providers of home visiting programs on topics including research design and administrative data matching.

(4) Report and Recommendation.—Not later than December 31, 2015, the Secretary shall submit to Congress regarding the programs conducted with grants under this section. The report required under this paragraph shall include—

(A) information regarding the extent to which eligible entities receiving grants under this section demonstrated improvements in each of the areas specified in subsection (d)(1)(A);

(B) information regarding any technical assistance provided under subsection (d)(1)(B)(iii)(I), including the type of any such assistance provided; and

(C) recommendations for such legislative or administrative action as the Secretary determines appropriate.

(5) Application of Other Provisions of Title.—

(I) In General.—Except as provided in paragraph (2), the other provisions of this title shall apply to a grant made under this section.

(II) Exceptions.—The following provisions of this title shall not apply to a grant made under this section in the same manner as such provisions apply to allotments made under section 502(c):—

(A) Section 502(b) (relating to prohibition on payments to excluded individuals and entities).

(B) Section 502(c) (relating to the use of funds for the purchase of technical assistance).

(C) Section 504(d) (relating to a limitation on administrative expenditures).

(D) Section 508 (relating to reports and audits), but only to the extent determined by the Secretary to be appropriate for grants made under this section.

(E) Section 507 (relating to penalties for false statements).

(F) Section 508 (relating to nondiscrimination).

(G) Section 509(a) (relating to the administration of the grant program).

(II) Appropriations.—

(1) In General.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary to carry out this section—

(A) $50,000,000 for fiscal year 2010; and

(B) $50,000,000 for fiscal year 2011; and

(C) $50,000,000 for fiscal year 2012; and

(D) $60,000,000 for fiscal year 2013; and

(E) $80,000,000 for fiscal year 2014; and

(F) $100,000,000 for 2015.

(2) Reservations.—Of the amount appropriated under this subsection for a fiscal year, the Secretary shall reserve—

(A) 3 percent for purposes of making grants to eligible entities that are Indian Tribes (or a consortium of Indian Tribes), Tribal Organizations, or Urban Indian Organizations; and

(B) 3 percent of such amount for purposes of carrying out subsections (d)(1)(B)(iii), (g), and (h)(3).

(3) Availability.—Funds made available to an eligible entity under this section for a fiscal year shall remain available for expenditure by the eligible entity through the end of the second succeeding fiscal year after award. Any funds that are not expended by the eligible entity during the period in which the funds are available under the preceding sentence may be utilized by nonprofit organizations under subsection (h)(2)(B).

(4) Definitions.—In this section:

(I) Eligible Entity.—The term ‘eligible entity’ means a State, an Indian Tribe, Tribal Organization, or Urban Indian Organization.

(II) Nonprofit Organization.—Only for purposes of awarding grants under subsection (b) of this section shall include a nonprofit organization with an established record of providing early childhood home visiting programs or initiatives in a State across several States.

(III) Eligible Family.—The term ‘eligible family’ means—

(A) a woman who is pregnant, and the father of the child if the father is available; or

(B) a parent or primary caregiver of a child, including grandparents or other relatives of the child, and foster parents, who are serving as the primary caregiver from birth to kindergarten entry, and including a noncustodial parent who has an ongoing relationship with, and at times provides custodial physical care.

(IV) Indian Tribe; Tribal Organization.—

(A) In General.—The terms ‘Indian Tribe’ and ‘Tribal Organization’ have the meanings given for such terms in section 2951, is amended by adding at the end of that section the following new section:

(SEC. 512. SERVICES TO INDIVIDUALS WITH A POSTPARTUM CONDITION AND THEIR FAMILIES.—Title V of the Social Security Act (42 U.S.C. 701 et seq.), as amended by section 2531, is amended by adding at the end of such section the following new section:

SEC. 512. SERVICES TO INDIVIDUALS WITH A POSTPARTUM CONDITION AND THEIR FAMILIES.

(a) In General.—In addition to any other payments made under this title to a State, the Secretary may make grants to eligible entities for projects for the establishment, operation, and coordination of effective and cost-efficient systems for the delivery of essential services to individuals with or at risk for postpartum conditions and their families.

(b) Certain Activities.—To the extent practicable and appropriate, the Secretary shall ensure that projects funded under section (a) provide education and services with respect to the diagnosis and management of postpartum conditions for individuals with or at risk for postpartum conditions and their families. The Secretary may allow such projects to include the following:

(A) Services to individuals at risk for, or having, postpartum conditions, including mental and physical health services, home health and personal care services, and case management services.

(B) Improving or enhancing inpatient care management services that ensure the well-being of the mother and family and the future development of the infant.

(C) The development of improved screening and diagnostic techniques.

(D) Clinical research for the development and evaluation of new treatments.

(E) Information and education programs for health care professionals and the public, which may include a coordinated national campaign to increase the awareness and treatment of postpartum conditions and the differences among racial and ethnic groups with respect to the conditions.
attendant care, homemaker services, day or respite care, and providing counseling on financial assistance and insurance.

(4) Providing education about postpartum conditions earlier diagnosis and treatment. Such education may include—

(A) providing complete information on postpartum conditions, symptoms, methods of prevention, and treatment resources; and

(B) in the case of a grantee that is a State, hospital, or birthing facility—

(i) education to new mothers and fathers, and other family members as appropriate, concerning postpartum conditions before new mothers leave the health facility; and

(ii) ensuring that training programs regarding such education are carried out at the health facility.

(d) ADMINISTRATION WITH OTHER PROGRAMS.—To the extent practicable and appropriate, the Secretary may integrate the grant program under this section with other grant programs carried out by the Secretary, including the program under section 330 of the Public Health Service Act.

(2) The Secretary shall establish requirements for grants made under this section that include a limit on the amount of grants funds that may be used for administration, accounting, reporting, or program oversight functions and a requirement for each eligible entity that receives a grant to submit, for each grant period, a report that describes how grants used were used during such period.

(e) TECHNICAL ASSISTANCE.—The Secretary may provide technical assistance to entities seeking a grant under this section in order to assist such entities in complying with the requirements of this section.

SECTION 513. PERSONAL RESPONSIBILITY EDUCATION.

(a) ALLOTMENTS TO STATES.—

(1) AMOUNT.—

(A) IN GENERAL.—For the purpose described in subsection (b), to the extent practicable and appropriate, the Secretary shall adjust on a pro rata basis the amount of the State allotments determined under this paragraph for a fiscal year to the extent necessary to comply with clause (1).

(B) MINIMUM AMOUNT.—

(i) IN GENERAL.—Each State allotment under this paragraph for a fiscal year shall be at least $250,000.

(ii) PRO RATA ADJUSTMENTS.—The Secretary shall adjust on a pro rata basis the amount of the State allotments determined under this paragraph for a fiscal year to the extent necessary to comply with clause (i).

(C) APPLICATION REQUIRED TO ACCESS ALLOTMENTS.—

(i) IN GENERAL.—A State shall not be paid its allotment for a fiscal year unless the State submits an application to the Secretary for the fiscal year and the Secretary approves the application (or requires changes to the application as specified by the Secretary). The State shall meet such additional requirements as the Secretary may specify.

(ii) REQUIREMENTS.—The State application shall include evidence that the State has complied with the requirements of this section in preparing and submitting the application and shall include the following, as well as such additional information as the Secretary may require:

(1) Based on data from the Centers for Disease Control and Prevention National Center for Health Statistics, the most recent pregnancy rates for each of fiscal years 2010 through 2014.

(2) The percentage is, with respect to a State, the proportion (expressed as a percentage) of—

(i) the number of individuals who have attained age 10 but not attained age 20 in the State; and

(ii) the number of such individuals in all States.

(3) AVAILABILITY OF STATE ALLOTMENTS.—Subject to paragraph (4)(A), amounts allotted to a State pursuant to this subsection for a fiscal year shall remain available for expenditure by the State through the end of the second succeeding fiscal year.

(4) AUTHORITY TO AWARD GRANTS FROM STATE ALLOTMENTS TO LOCAL ORGANIZATIONS AND ENTITIES IN NONPARTICIPATING STATES.—

(A) GRANTS FROM UNEXPAID ALLOTMENTS.—If a State does not submit an application for expenditure of funds under this section for a fiscal year to the Secretary for such fiscal year, the Secretary may award grants under this paragraph for such fiscal year to the extent necessary to comply with this section to local organizations and entities that apply for such grants. If the Secretary determines that a State has made grants under this section or to a local organization or entity for such programs or initiatives for which amounts from allotments and grants under this sub- title or to a local organization or entity for such programs, or initiatives for which amounts from allotments and grants under this sub-section may be expended is less than the amount expended by the State, organization, or entity for such programs or initiatives for fiscal year 2010.

(B) DATA COLLECTION AND REPORTING.—A State shall use a system that tracks and reports funds under this section shall cooperate with such requirements relating to the collection of data and information and report on outcomes resulting from the programs and activities carried out with such funds, as the Secretary shall specify.

(C) PURPOSE.—If a State fails to submit an application under subsection (a)(1) to a State to enable the State (or, in the case of grants

youth with HIV/AIDS, pregnant youth who are under 21 years of age, mothers who are under 21 years of age, and youth residing in areas with high birth rates for youth.

(2) STATE YOUTH POPULATION PERCENTAGE.—

(A) IN GENERAL.—For purposes of paragraphs (1)(A)(i) and (ii), the State youth population percentage is, with respect to a State, the proportion (expressed as a percentage) of—

(i) the number of individuals who have attained age 10 but not attained age 20 in the State; and

(ii) the number of such individuals in all States.

(B) DETERMINATION OF NUMBER OF YOUTH.—The number of individuals described in clauses (i) and (ii) of subparagraph (A) in a State shall be determined on the basis of the most recent Bureau of the Census data.

(3) AVAILABILITY OF STATE ALLOTMENTS.—Subject to paragraph (4)(A), amounts allotted to a State pursuant to this subsection for a fiscal year shall remain available for expenditure by the State through the end of the second succeeding fiscal year.

(4) AUTHORITY TO AWARD GRANTS FROM STATE ALLOTMENTS TO LOCAL ORGANIZATIONS AND ENTITIES IN NONPARTICIPATING STATES.—

(A) GRANTS FROM UNEXPAID ALLOTMENTS.—If a State does not submit an application for expenditure of funds under this section for a fiscal year to the Secretary for such fiscal year, the Secretary may award grants under this paragraph for such fiscal year to the extent necessary to comply with this section to local organizations and entities that apply for such grants. If the Secretary determines that a State has made grants under this section or to a local organization or entity for such programs or initiatives for which amounts from allotments and grants under this sub-
made under subsection (a)(4)(B), to enable a local organization or entity to carry out personal responsibility education programs consistent with this subsection.

(2) PERSONAL RESPONSIBILITY EDUCATION PROGRAMS.—

(A) IN GENERAL.—In this section, the term ‘personal responsibility education program’ means a program that is designed to educate adolescents on—

(i) both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, including HIV/AIDS, consistent with the requirements of subparagraph (B); and

(ii) subsection 3 of the adulthood preparation subjects described in subparagraph (C).

(B) REQUIREMENTS.—The requirements of this subparagraph are the following:

(i) Evidence-based effective programs or substantially incorporates elements of effective programs that have been proven on the basis of rigorous scientific research to change behavior, which means delaying sexual activity, increasing condom or contraceptive use for sexually active youth, or reducing pregnancy among youth.

(ii) The program is medically-accurate and complete.

(iii) The program includes activities to educate youth who are sexually active regarding responsible sexual behavior with respect to both abstinence and the use of contraception.

(iv) The program places substantial emphasis on both abstinence and contraception for the prevention of pregnancy among youth and sexually transmitted infections.

(v) The program provides age-appropriate information and activities.

(vi) The information and activities carried out within the development of this program shall be in the cultural context that is most appropriate for individuals in the particular population group to which they are directed.

(C) ADULTHOOD PREPARATION SUBJECTS.—

The adulthood preparation subjects described in this subparagraph are the following:

(i) Healthy relationships, such as positive self-esteem and relationship dynamics, friendships, dating, romantic involvement, marriage, and family interactions.

(ii) Developmental accomplishments, such as the development of healthy attitudes and values about adolescent growth and development, body image, racial and ethnic diversity, and other similar document recognized under the term ‘healthy relationships’.

(iii) Financial literacy.

(iv) Parent-child communication.

(v) Educational and career success, such as preparing skills for employment preparation, job seeking, independent living, financial self-sufficiency, and workplace productivity.

(vi) Healthy life skills, such as goal-setting, decision making, negotiation, communication and interpersonal skills, and stress management.

(c) RESERVATIONS OF FUNDS.—

(1) GRANTS TO IMPLEMENT INNOVATIVE STRATEGIES.—From the amount appropriated under subsection (a) for the fiscal year, the Secretary shall reserve $10,000,000 of such amount for purposes of awarding grants to entities to implement innovative youth pregnancy prevention strategies and targeted services to high-risk, vulnerable, and culturally-underrepresented youth populations, including youth in foster care, homeless youth, HIV/AIDS, pregnant women who are under 21 years of age and their partners, mothers who are under 21 years of age and their partners, and youth residing in high birth rate areas.

(ii) (A) in the first sentence, by striking ''1998'' and inserting ''2010 through 2014'';

(b) INDEPENDENT LIVING EDUCATION.—Sec-

tion 510 of the Social Security Act (42 U.S.C. 1416(c)) is amended by inserting ''includes'' in the first sentence, by striking ''1998'' and inserting ''2010 through 2014'';

(ii) (A) in the first sentence, by striking ''1998'' and inserting ''2010 through 2014'';

(b) INDEPENDENT LIVING EDUCATION.—Sec-

tion 477(b)(3) of such Act (42 U.S.C. 677(b)(3)) is amended by adding at the end the following:

(iii) Section 508 (relating to non- discrimination).
TITLE III—IMPROVING THE QUALITY AND EFFICIENCY OF HEALTH CARE

Subtitle A—Transforming the Health Care Delivery System

PART I—LINKING PAYMENT TO QUALITY OUTCOMES UNDER THE MEDICARE PROGRAM

SEC. 3001. HOSPITAL VALUE-BASED PURCHASING PROGRAM.

(a) PROGRAM.—

(1) IN GENERAL.—Section 1886 of the Social Security Act (42 U.S.C. 1395ww), as amended by section 4102(a) of the HITECH Act (Public Law 111–5), is amended by adding at the end the following:

(II) for which, during the performance period for such fiscal year; or

(III) for which there are not a minimum number (as determined by the Secretary) of measures that apply to the hospital for the performance period for such fiscal year; or

(IV) for which there for not a minimum number (as determined by the Secretary) of cases for the measures that apply to the hospital for the performance period for such fiscal year.

(bb) Heart failure.

(ii) Historical performance standards; and

(iii) Improvement rates; and

(vii) Steps to ensure that the components established under this subsection.

(c) HOSPITAL VALUE-BASED PURCHASING PROGRAM.

(1) ESTABLISHMENT.—

(A) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary shall establish, for a hospital, a value-based purchasing program (in this subsection referred to as the ‘Program’) under which value-based incentive payments are made in a fiscal year to hospitals that meet the performance standards under paragraph (3) for the performance period for such fiscal year (as established under paragraph (4)).

(B) PROGRAM TO BEGIN IN FISCAL YEAR 2013.—The Program shall apply to payments for discharges occurring on or after October 1, 2012.

(2) APPLICABILITY OF PROGRAM TO HOSPITALS.—

(A) IN GENERAL.—For purposes of this subsection, subject to clause (ii), the term ‘hospital’ means a hospital if such hospital if such hospital does not furnish services appropriate to such measure.

(B) APPROPRIATE DISTRIBUTION.—The Secretary may not select a measure under subparagraph (A) for use under the Program with respect to a performance period unless such measure has been selected under subsection (b)(3)(B)(viii) and included on the Hospital Compare Internet website for at least 1 year prior to the beginning of such performance period.

(1) TIME REQUIREMENT FOR PRIOR REPORTING AND NOTICE.—The Secretary may not select a measure under paragraph (3)(A) unless such measure has been selected by the Secretary under subparagraph (A) of section 1886(d)(3)(B)(vi) for the fiscal year involved, including whether a significant proportion of hospitals failed to meet the performance standard during previous performance periods;

(2) HIGHER OF ACHIEVEMENT OR IMPROVEMENT.—The methodology developed under subparagraph (A) shall provide that the hospital performance score is determined using the higher of its achievement or improvement score for each measure.

(ii) Practical experience with the measures selected under paragraph (2) for a performance period (as established under paragraph (4)).

(3) MEASURES.—

(i) TIME REQUIREMENT FOR PRIOR REPORTING AND NOTICE.—The Secretary may not select a measure under paragraph (3)(A) unless such measure has been selected by the Secretary under subparagraph (A) of section 1886(d)(3)(B)(vi) for the fiscal year involved, including whether a significant proportion of hospitals failed to meet the performance standard during previous performance periods;

(1) IN GENERAL.—In the case of a hospital that the Secretary determines meets (or exceeds in performance under paragraph (3) for the performance period for a fiscal year (as established under paragraph (4)), the Secretary shall increase the base operating DRG payment amount (as defined in paragraph (7)(D)), as determined after application of paragraph (7)(B)(i), for a hospital for each discharging occurring in such fiscal year by the value-based incentive payment amount.

(4) MEASUREMENT AND NOTICE.—The methodology developed under subparagraph (A) shall provide for an assessment of each measure's performance scores receiving the largest value-based incentive payments.

(1) ESTABLISHMENT.—The Secretary shall establish, for each hospital, a hospital performance score that includes measures of ‘Medicare spending per beneficiary’. Such measures shall be adjusted for factors such as age, sex, race, severity of illness, and other factors that the Secretary determines appropriate.

(2) LIMITATIONS.—

(iii) Weights.—The methodology developed under subparagraph (A) shall provide for the assignment of weights for categories of measures as the Secretary determines appropriate.

(iv) NO MINIMUM PERFORMANCE STANDARD.—The Secretary shall set a minimum performance standard in determining the hospital performance score for any hospital.

(v) REFLECTION OF MEASURES APPLICABLE TO THE HOSPITAL.—The hospital performance score for a hospital shall reflect the measures that apply to the hospital.

(B) IN GENERAL.—In the case of a hospital that the Secretary determines meets (or exceeds in performance under paragraph (3) for the performance period for a fiscal year (as established under paragraph (4)), the Secretary shall increase the base operating DRG payment amount (as defined in paragraph (7)(D)), as determined after application of paragraph (7)(B)(i), for a hospital for each discharging occurring in such fiscal year by the value-based incentive payment amount.

(2) IN GENERAL.—The performance standards established under subparagraph (A) shall include levels of achievement and improvement.

(C) TIMING OF ESTABLISHMENT.—The performance standards established under subparagraph (A) not later than 60 days prior to the beginning of the performance period for the fiscal year involved.

(D) CONSIDERATIONS IN ESTABLISHING PERFORMANCE STANDARDS.—In establishing performance standards, with respect to measures under this paragraph, the Secretary shall take into account appropriate factors, such as—

(1) Exclusive of value-based incentive payments under paragraph (6) among hospitals achieving different levels of hospital performance scores, with hospitals having the highest hospital performance scores receiving the largest value-based incentive payments.

(3) EFFECTIVE DATE.—The amendments made by this section take effect on October 1, 2013.
(ii) the value-based incentive payment percentage specified under subparagraph (C) for the hospital for such fiscal year.

(C) VALUE-BASED INCENTIVE PAYMENT PERCENTAGE.—

(i) IN GENERAL.—The Secretary shall specify a value-based incentive payment percentage for a hospital for a fiscal year.

(ii) NO EFFECT ON OTHER PAYMENTS.—Payments described in items (aa) and (bb) of subparagraph (D)(1)(II) for a hospital determined as if this subsection had not been enacted.

(C) APPLICABLE PERCENT DEFINED.—

(1) IN GENERAL.—For purposes of subparagraph (B), the term ‘applicable percentage’ means—

(1) with respect to fiscal year 2013, 1.0 percent;

(ii) with respect to fiscal year 2014, 1.25 percent;

(iii) with respect to fiscal year 2015, 1.5 percent;

(iv) with respect to fiscal year 2016, 1.75 percent; and

(v) with respect to fiscal year 2017 and succeeding fiscal years, 2 percent.

(D) OPERATING DRG PAYMENT AMOUNT DEFINED.—

(i) IN GENERAL.—Except as provided in clause (ii), in this subsection, the term ‘base operating payment amount’ means—

(1) the payment amount that would otherwise be made under subparagraph (d) (determined without regard to subsection (q)) for a discharge if this subsection did not apply; reduced by—

(aa) payments under paragraphs (5)(A), (5)(B), (5)(F), and (12) of subsection (d); and

(bb) such other payments under subsection (d) as determined appropriate by the Secretary.

(ii) SPECIAL RULES FOR CERTAIN HOSPITALS.—

(A) SOLE COMMUNITY HOSPITALS AND MEDICAIRE-DEPENDENT, SMALL RURAL HOSPITALS.—In the case of a medicare-dependent, small rural hospital (with respect to discharges occurring during fiscal years 2012 and 2013) or a sole community hospital, in applying subparagraph (A)(i), the payment amount that would otherwise be made under subparagraph (d) shall be determined without regard to subparagraphs (I) and (L) of subsection (b)(3) and subparagraphs (D) and (G) of subsection (b)(5).

(B) HOSPITALS PAID UNDER SECTION 1814.—In the case of a hospital that is paid under section 1814(b)(3), the term ‘base operating payment amount’ means the payment amount under such section.

(8) ANNOUNCEMENT OF NET RESULT OF ADJUSTMENTS.—Under the Program, the Secretary shall, prior to the fiscal year involved, inform each hospital of the adjustments to payments to the hospital for discharges occurring in such fiscal year under paragraphs (6) and (7)(B)(i).

(9) NO EFFECT IN SUBSEQUENT FISCAL YEARS.—The value-based incentive payment under paragraph (6) and the payment reduction under paragraph (7)(B)(i) shall each apply only with respect to the fiscal year involved, and the Secretary shall not take into account such value-based incentive payment or payment reduction in making payments to a hospital under this section in a subsequent fiscal year.

(10) PUBLIC REPORTING.—

(A) HOSPITAL QUALITY INFORMATION.—

(i) IN GENERAL.—The Secretary shall make information available to the public regarding the performance of individual hospitals under the Program, including—

(I) the performance of the hospital with respect to each measure that applies to the hospital;

(II) the performance of the hospital with respect to each condition or procedure; and

(iii) the hospital performance score assessing the total performance of the hospital.

(ii) OPPORTUNITY TO REVIEW AND SUBMIT CORRECTIONS.—The Secretary shall ensure that a hospital has the opportunity to review, and submit corrections for, the information to be made public with respect to the hospital under clause (i) prior to such information being made public.

(iii) WAREHOUSE INFORMATION.—Information shall be posted on the Hospital Compare Internet website in an easily understandable format.

(B) AGGREGATE INFORMATION.—The Secretary shall require hospitals to submit data on measures that have been endorsed by the Secretary for which a feasible and practical methodology determined to be appropriate to maintain incentives for hospitals to treat patients with severe illnesses or conditions.

(11) DETERMINATION OF THE AMOUNT OF VALUE-BASED INCENTIVE PAYMENTS.—

(A) APPEALS.—The Secretary shall establish a process by which hospitals may appeal the calculation of a hospital’s performance assessment score, the performance standards established under paragraph (3)(A) and the hospital performance score under paragraph (5). The Secretary shall ensure that such process provides for the resolution of such appeals in a timely manner.

(B) LIMITATION ON REVIEW.—Except as provided in subparagraph (A), there shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the following:

(1) the methodology used to determine the amount of value-based incentive payments under paragraph (6) and the determination of such amount.

(ii) the determination of the amount of funding available for such value-based incentive payments under paragraph (7)(A) and the payment reduction under paragraph (7)(B)(i).

(iii) the establishment of the performance standards under paragraph (3) and the performance period under paragraph (4).

(iv) the measures selected under subparagraph (b)(3)(B)(ii) and the measures selected under paragraph (2).

(v) the methodology developed under paragraph (5) that is used to calculate hospital performance scores and the calculation of such scores.

(vi) the validation methodology specified in subsection (b)(7)(A).

(C) CONSULTATION WITH SMALL HOSPITALS.—The Secretary shall consult with small and rural hospitals on the application of the Program to such hospitals.

(12) PROMULGATION OF REGULATIONS.—The Secretary shall promulgate regulations to carry out the Program, including the selection of measures under paragraph (2), the methodology developed under paragraph (5) that is used to calculate hospital performance scores, and the methodology used to determine the amount of value-based incentive payments under paragraph (6).'

(2) AMENDMENTS FOR REPORTING OF HOSPITAL QUALITY INFORMATION.—

(A) IN GENERAL.—Section 1890(a)(3)(B)(vii) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(vii)) is amended—

(i) by striking ‘‘data submitted’’ and inserting ‘‘information regarding measures submitted’’; and

(ii) by adding at the end the following sentence: ‘‘The Secretary may require hospitals to submit data on measures that are not used for the determination of value-based incentive payments under paragraph (6).’’;

(B) IN SUBCLAUSE (V), by striking ‘‘beginning with fiscal year 2008’’ and inserting ‘‘for fiscal years 2008 through 2012’’;

(C) IN subclause (VII), in the first sentence, by striking ‘‘data submitted’’ and inserting ‘‘information regarding measures submitted’’;

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

(VIII) Effective for payments beginning with fiscal year 2013, with respect to quality measures for outcomes of care, the Secretary shall provide for risk adjustment and the Secretary determines to be appropriate to maintain incentives for hospitals to treat patients with severe illnesses or conditions.

(IX) Subject to the Secretary’s determination as to the feasibility and practicality of the methodology, for payments beginning with fiscal year 2013, each measure specified by the Secretary under this clause shall be endorsed by the entity with a contract under section 1890(a).

(bb) In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical methodology 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 the measures that are endorsed or adopted by a consensus organization identified by the Secretary.

(X) To the extent practicable, the Secretary shall have the input from consensus organizations and other stakeholders, take steps to ensure that the measures specified by the Secretary under this clause are coordinated and aligned with quality measures applicable to—

(aa) physicians under section 1848(k); and

(bb) other providers of services and suppliers.

(XI) The Secretary shall establish a process to validate measures specified under this clause as appropriate. Such process shall include the auditing of a number of randomly selected hospitals sufficient to ensure validity of the reporting program under this
(iii) the appropriateness of the Medicare program sharing in any savings generated through the hospital value-based purchasing program; and
(iv) any other areas determined appropriate by the Secretary.

(B) REPORT.—Not later than January 1, 2016, the Secretary of Health and Human Services shall submit a report containing the results of the study conducted under subparagraph (A), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

(b) VALUE-BASED PURCHASING DEMONSTRATION PROGRAM—

(1) VALUE-BASED PURCHASING DEMONSTRATION PROGRAM FOR INPATIENT CRITICAL ACCESS HOSPITALS.—

(A) ESTABLISHMENT.—

(i) IN GENERAL.—Not later than 2 years after the date of enactment of this Act, the Secretary of Health and Human Services shall conduct a demonstration program under which the Secretary establishes a value-based purchasing program under the Medicare program under title XVIII of the Social Security Act for critical access hospitals (as defined in section 1861(mm) of the Social Security Act) for the purpose of ensuring that such hospitals are representative of the spectrum of such hospitals that participate in the Medicare program.

(B) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act as may be necessary to carry out the demonstration program under this paragraph.

(C) BUDGET NEUTRALITY REQUIREMENT.—In conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.

(2) VALUE-BASED PURCHASING DEMONSTRATION PROGRAM FOR HOSPITALS EXCLUDED FROM HOSPITAL VALUE-BASED PURCHASING PROGRAM AS A RESULT OF INADVERTENT NUMBERS OF MEASURES AND CASES.—

(A) ESTABLISHMENT.—

(i) IN GENERAL.—Not later than 2 years after the date of enactment of this Act, the Secretary shall establish a demonstration program under which the Secretary establishes a value-based purchasing program under title XVIII of the Social Security Act for applicable hospitals (as defined in clause (ii)) with respect to inpatient hospital services (as defined in section 1861(b) of the Social Security Act (42 U.S.C. 1395x(b))) in order to test innovative methods of measuring and rewarding quality and efficient health care furnished by such hospitals.

(ii) APPLICABLE HOSPITAL DEFINED.—For purposes of this paragraph, the term ‘‘applicable hospital’’ means a hospital described in subsection (III) or (IV) of section 1866(o)(1)(C)(i) of the Social Security Act, as added by subsection (a)(1).

(iii) DURATION.—The demonstration program under this paragraph shall be conducted for a 3-year period.

(iv) SITES.—The Secretary shall conduct the demonstration program under this paragraph at an appropriate number (as determined by the Secretary) of applicable hospitals. The Secretary shall ensure that such hospitals are representative of the spectrum of such hospitals that participate in the Medicare program.

(3) VALUE-BASED PURCHASING DEMONSTRATION PROGRAM FOR SMALL HOSPITALS.—

(A) STUDY.—The Comptroller General of the United States shall conduct a study on the performance of the hospital value-based purchasing program established under section 1886(o) of the Social Security Act, as added by paragraph (1). Such study shall include an analysis of the impact of such program on—

(i) the quality of care furnished to Medicare and other federal health care program beneficiaries (including the care of Medicare beneficiaries); and

(ii) the performance standards applicable under such hospital value-based purchasing program; and

(B) REPORT.—

(i) INTERIM REPORT.—Not later than October 1, 2015, the Comptroller General of the United States shall submit to Congress an interim report containing the results of the study conducted under subparagraph (A), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

(ii) FINAL REPORT.—Not later than July 1, 2017, the Comptroller General of the United States shall submit to Congress a report containing the results of the study conducted under subparagraph (A), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

(4) IHS STUDY AND REPORT.—

(A) STUDY.—The Secretary of Health and Human Services shall conduct a study on the performance of the hospital value-based purchasing program established under section 1886(o) of the Social Security Act, as added by paragraph (1). Such study shall include an analysis—

(i) of ways to improve the hospital value-based purchasing program and ways to address the consequences that may occur as a result of such program;

(ii) of whether the hospital value-based purchasing program resulted in lower spending under the Medicare program under title XVIII of such Act or other financial savings to hospitals; and

(iii) the appropriateness of the Medicare program sharing in any savings generated through the hospital value-based purchasing program; and

(iv) any other area determined appropriate by the Secretary.

(B) REPORT.—Not later than January 1, 2016, the Secretary of Health and Human Services shall submit a report containing the results of the study conducted under subparagraph (A), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

(5) HHS STUDY AND REPORT.—

(A) STUDY.—The Secretary of Health and Human Services shall conduct a study on the performance of the hospital value-based purchasing program established under section 1886(o) of the Social Security Act, as added by paragraph (1). Such study shall include an analysis—

(i) of ways to improve the hospital value-based purchasing program and ways to address the consequences that may occur as a result of such program;

(ii) of whether the hospital value-based purchasing program resulted in lower spending under the Medicare program under title XVIII of such Act or other financial savings to hospitals; and

(iii) the appropriateness of the Medicare program sharing in any savings generated through the hospital value-based purchasing program; and

(iv) any other area determined appropriate by the Secretary.

(B) REPORT.—Not later than January 1, 2016, the Secretary of Health and Human Services shall submit a report containing the results of the study conducted under subparagraph (A), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

(6) BUDGET NEUTRALITY REQUIREMENT.—In conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.

(B) REPORT.—Not later than 18 months after the completion of the demonstration program under this paragraph, the Secretary shall submit to Congress a report on the demonstration program together with—

(i) recommendations on the establishment of a permanent value-based purchasing program under the Medicare program for applicable hospitals with respect to inpatient hospital services; and

(ii) recommendations for such other legislation and administrative action as the Secretary determines appropriate.
(ii) by striking ‘‘under subparagraph (D)(iii) of such subsection’’ and inserting ‘‘under subsection (a)(5)(D)(iii) or the quality reporting period under subsection (a)(5)(D)(iii)’’ respectively.

(b) INCENTIVE PAYMENT ADJUSTMENT FOR QUALITY REPORTING.—Section 1848(a)(1) of the Social Security Act (42 U.S.C. 1395w–4(a)) is amended by adding at the end the following new paragraph:

‘‘(8) INCENTIVES FOR QUALITY REPORTING.—
‘‘(A) ADJUSTMENT.—

‘‘(i) IN GENERAL.—With respect to covered professional services furnished by an eligible professional during 2015 or any subsequent year, if the eligible professional does not satisfactorily submit data on quality measures for covered professional services for the quality reporting period for the year (as determined under subsection (m)(3)(A)), the fee schedule amount for such services furnished by such professional during the year (including the fee schedule amount for purposes of determining a payment based on such amount) shall be equal to the applicable percent of the fee schedule amount that would otherwise apply to such services under this subsection (determined after application of paragraphs (3), (5), and (7), but without regard to this paragraph).

‘‘(ii) APPLICABLE PERCENT.—For purposes of clause (i), the term ‘applicable percent’ means—

‘‘(I) for 2015, 98.5 percent; and

‘‘(II) for 2016 and each subsequent year, 98 percent.

(c) APPLICABILITY.—

‘‘(i) PHYSICIAN REPORTING SYSTEM RULES.—Paragraphs (5), (6), and (8) of subsection (k) shall apply for purposes of this paragraph in the same manner as they apply for purposes of such subsection.

‘‘(ii) INCENTIVE PAYMENT VALIDATION RULES.—Classes (ii) and (ii) of subsection (m)(3)(A) shall apply for purposes of this paragraph in a similar manner as they apply for purposes of such subsection.

‘‘(C) DEFINITIONS.—For purposes of this paragraph:

‘‘(i) ELIGIBLE PROFESSIONAL; COVERED PROFESSIONAL SERVICES.—The terms ‘eligible professional’ and ‘covered professional services’ have the meanings given such terms in subsection (k)(3).

‘‘(ii) PHYSICIAN REPORTING SYSTEM.—The term ‘physician reporting system’ means the system established under subsection (k)(7).

‘‘(iii) QUALITY REPORTING PERIOD.—The term ‘quality reporting period’ means, with respect to a year, a period specified by the Secretary.

(c) MAINTENANCE OF CERTIFICATION PROGRAMS.—

(1) IN GENERAL.—Section 1848(k)(4) of the Social Security Act (42 U.S.C. 1395w–4(k)(4)) is amended by inserting ‘‘or through a Maintenance of Certification program operated by a specialty body of the American Board of Medical Specialties that meets the criteria for such a registry’’ after ‘‘Database’’.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply for years after 2010.

(d) INTEGRATION OF PHYSICIAN QUALITY REPORTING AND EHR REPORTING.—Section 1848(m) of the Social Security Act (42 U.S.C. 1395w–4(m)) is amended by adding at the end the following new paragraph:

‘‘(7) INTEGRATION OF PHYSICIAN QUALITY REPORTING AND EHR REPORTING.—Not later than January 1, 2012, the Secretary shall develop a plan to integrate reporting on quality measures under this subsection with reporting requirements under subsection (o) relating to the use of electronic health records. Such integration shall consist of the following:

‘‘(A) The selection of measures, the reporting of which would both document—

‘‘(i) meaningful use of an electronic health record for purposes of subsection (o); and

‘‘(ii) quality of care furnished to an individual.

‘‘(B) Such other activities as specified by the Secretary.

(e) FEEDBACK.—Section 1848(m)(5) of the Social Security Act (42 U.S.C. 1395w–4(m)(5)) is amended by adding at the end the following new subparagraph:

‘‘(H) FEEDBACK.—The Secretary shall provide timely feedback to eligible professionals on the performance of the eligible professional with respect to satisfactorily submitting data on quality measures under this subsection.’’

(f) APPEALS.—Such section is further amended—

(1) in subparagraph (E), by striking ‘‘There shall’’ and inserting ‘‘Except as provided in subparagraph (I), there shall’’; and

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

‘‘(1) INFORMAL APPEALS PROCESS.—The Secretary shall, by no later than January 1, 2011, establish and have in place an informal process for eligible professionals to seek a review of the determination that an eligible professional has satisfactorily submitted data on quality measures under this subsection.’’

(g) SEC. 3003. IMPROVEMENTS TO THE PHYSICIAN QUALITY REPORTING SYSTEM.

(1) IN GENERAL.—Section 1848(k)(4) of the Social Security Act (42 U.S.C. 1395w–4(k)(4)) is amended by adding at the end the following new paragraph:

‘‘(A) in paragraph (1)—

(A)(i) by striking ‘‘the Secretary’’ and inserting ‘‘the Secretary and establishing—

‘‘(I) ESTABLISHMENT.—The Secretary;’’

(A)(ii) in clause (i), as added by clause (i), by striking ‘‘the ‘Program’’ and all that follows the through the period at the end of the second sentence and inserting ‘‘the ‘Program’’;’’ and

(A)(iii) by adding at the end the following new clauses:

‘‘(ii) REPORTS ON RESOURCES.—The Secretary shall use claims data under this title (and may use other data) to provide conformance reports to physicians and, as determined appropriate by the Secretary, to groups of physicians that measure the resources involved in furnishing care to individuals under this title.

‘‘(iii) INCLUSION OF CERTAIN INFORMATION.—If determined appropriate by the Secretary, the Secretary may include information on the quality of care furnished to individuals under this title by the physician (or group of physicians) in such reports.’’; and

(B) in subparagraph (B), by striking ‘‘subparagraph (C);’’.

(h) CONFORMING AMENDMENT.—Section 1848(m) of the Social Security Act (42 U.S.C. 1395w–4(m)) is amended by—

(A) in the matter preceding subparagraph (C), by striking ‘‘(ii)’’;

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

‘‘(10) COORDINATION WITH OTHER VALUE-BASED PURCHASING REFORMS.—The Secretary shall coordinate the Program with the value-based payment modifier established under subsection (b) and (c), including the determination of an episode of care under such methodology.

(i) COORDINATION WITH OTHER VALUE-BASED PURCHASING REFORMS.—The Secretary shall coordinate the Program with the value-based payment modifier established under subsection (b) and (c), including the determination of an episode of care under such methodology.

(j) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the establishment of the methodology under subsection (c), including the determination of an episode of care under such methodology.

(k) TREATMENT OF GROUPS.—Such term includes, as the Secretary determines appropriate, a group of physicians.

(l) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the establishment of the methodology under subsection (c), including the determination of an episode of care under such methodology.

(m) CONFORMING AMENDMENT.—Section 1890(b) of the Social Security Act (42 U.S.C. 1395aa(b)) is amended by adding at the end the following new paragraph:

‘‘(6) REVIEW AND ENDORSEMENT OF EPISODE OF CARE UNDER THE PHYSICIAN FEEDBACK PROGRAM.—The entity shall provide for the review and, as appropriate, the endorsement of the episode of care developed by the Secretary under section 1890(a). Such review shall be conducted on an expedited basis.’’
(a) LONG-TERM CARE HOSPITALS.—Section 1886(m) of the Social Security Act (42 U.S.C. 1395ww(m)), as amended by section 340(c), is amended by adding at the end the following new paragraph:

"(3) 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.

(b) INPATIENT REHABILITATION HOSPITALS.—Section 1886(g)(2) of the Social Security Act (42 U.S.C. 1395w(v)(2)) is amended—

"(1) by redesignating paragraph (5) as paragraph (6); and

"(2) by inserting after paragraph (4) the following new paragraph:

"(5) QUALITY REPORTING.—

"(A) REDUCTION IN UPDATE FOR FAILURE TO REPORT.—

"(i) IN GENERAL.—For purposes of fiscal year 2014 and each subsequent fiscal year, in the case of a hospice program that does not submit data to the Secretary in accordance with subparagraph (C) with respect to such a fiscal year, after determining the market basket percentage increase by 2 percentage points, the Secretary shall reduce such market basket percentage increase by 2 percentage points.

"(ii) SPECIAL RULE.—The application of the methodology under subparagraph (A) shall apply only with respect to the fiscal year involved and may not result in payment rates for the preceding fiscal year being less than such payment rates for the preceding fiscal year.

"(B) NONCUMULATIVE APPLICATION.—Any reduction under subparagraph (A) shall apply only with respect to the fiscal year involved and may not result in payment rates for the preceding fiscal year being less than such payment rates for the preceding fiscal year.

(c) HOSPICE PROGRAMS.—For fiscal year 2014 and each subsequent fiscal year, each hospice program 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.

"(1) 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.

(d) QUALITY MEASURES.—

"(1) 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.

(e) TIME FRAME.—Not later than October 1, 2012, the Secretary shall publish the measures selected under this subparagraph that will be applicable with respect to fiscal year 2014.

(f) PUBLIC AVAILABILITY OF DATA SUBMITTED.—The Secretary shall establish procedures for making data submitted under subparagraph (C) available to the public. Such procedures shall ensure that a hospice program has the opportunity to review the data that is to be made public with respect to the hospice program prior to such data being made public. The Secretary shall report quality measures that relate to hospice care provided by hospice programs on the Internet website of the Centers for Medicare & Medicaid Services.

(g) QUALITY REPORTING BY CANCER HOSPITALS.—Section 1866 of the Social Security Act (42 U.S.C. 1395ccc) is amended—

"(1) in subsection (a), by striking “and” at the end;

"(2) in subsection (b), by striking the period at the end and inserting “, and”;

"(3) by adding at the end the following new subparagraph:

"(W) in the case of a hospital described in section 1886(d)(1)(B)(v), the report quality data to the Secretary in accordance with subsection (k); “;

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

"(k) QUALITY REPORTING BY CANCER HOSPITALS.—

"(1) IN GENERAL.—For purposes of fiscal year 2014 and each subsequent fiscal year, a hospital described in section 1886(d)(1)(B)(v) shall submit data to the Secretary in accordance with paragraph (2) with respect to such a fiscal year.

"(2) SUBMISSION OF QUALITY DATA.—For fiscal year 2014 and each subsequent fiscal year,
each hospital described in such section shall submit to the Secretary data on quality measures specified under paragraph (3). Such data shall be submitted in a form and manner, and endorsed by the Secretary, as determined by the Secretary for purposes of this subparagraph.

"(3) QUALITY MEASURES.—

"(A) IN GENERAL.—Subject to subparagraph (B), after the publication of the plan developed under this paragraph the Secretary may specify any measure or set of measures that reflect health outcomes for individuals enrolled under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395a) that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

"(B) Time frame.—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.

"(C) TIME FRAME.—Not later than October 1, 2012, the Secretary shall publish the measures selected under this paragraph that will be applicable with respect to fiscal year 2014.

"(D) Public availability of data submitted.—The Secretary shall establish procedures for making data submitted under paragraph (4) available to the public. Such procedures shall ensure that a hospital described in section 1886(d)(1)(B)(v) has the opportunity to review the data that is to be made public with respect to the hospital prior to such data being made public. The Secretary shall report quality measures of process, structure, outcome, patients' perspective on care, efficiency, and costs of care that relate to services furnished in such hospitals on the Internet on the Websites of the Centers for Medicare and Medicaid Services.

SEC. 3006. PLANS FOR A VALUE-BASED PURCHASING PROGRAM FOR SKILLED NURSING FACILITIES AND HOME HEALTH AGENCIES.

(a) SKILLED NURSING FACILITIES.—

"(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall develop a plan to implement a value-based purchasing program for payments under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395c) and section 1890A of the Social Security Act (42 U.S.C. 1395aaa) and section 1890A such Act, as added by section 3014) to the extent feasible and practicable, based on a comparison of the quality of care furnished under a contract with the Secretary for an area that is identified by the Secretary to as a "value-based payment area." The Secretary shall consider the following issues:

"(i) The ongoing development, selection, and modification process for measures (including under section 1890 of the Social Security Act (42 U.S.C. 1395c) and section 1890A such Act, as added by section 3014), to the extent feasible and practicable, of all dimensions of quality and efficiency in skilled nursing facilities.

"(II) The measures of quality and cost established under paragraphs (2) and (3), respectively.

"(b) MEASURES.—For purposes of paragraph (1), costs shall be evaluated, to the extent practicable, based on a composite of appropriate measures of costs established by the Secretary (such as the composite measure under the methodology established under subsection (n)(9)(C)(iii)) that eliminate the effect of geographic adjustments in payment rates (as described in subsection (e)), and take into account risk factors (such as socioeconomic and demographic characteristics, etc.) and health outcomes for individuals (such as to recognize that less healthy individuals may require more intensive interventions) and other factors determined appropriate by the Secretary.

"(c) Implementation.—

"(i) The Secretary shall establish appropriate measures of the quality of care furnished by a physician or group of physicians to individuals enrolled under this part, such as measures that reflect health outcomes. Such measures shall be risk adjusted as determined appropriate by the Secretary.

"(ii) The Secretary shall seek endorsement of the measures established under this subparagraph by the entity with a contract under section 1890(a).

"(3) COSTS.—For purposes of paragraph (1), costs shall be evaluated, to the extent practicable, based on a composite of appropriate measures of costs established by the Secretary (such as the composite measure under the methodology established under subsection (n)(9)(C)(iii)) that eliminate the effect of geographic adjustments in payment rates (as described in subsection (e)), and take into account risk factors (such as socioeconomic and demographic characteristics, etc.) and health outcomes for individuals (such as to recognize that less healthy individuals may require more intensive interventions) and other factors determined appropriate by the Secretary.

"(4) IMPLEMENTATION.—

"(A) Report to Congress.—Not later than January 1, 2012, the Secretary shall submit to the Congress a report containing the plan developed under paragraph (1).

"(B) Provision of information during initial performance period.—During the initial performance period, the Secretary shall, to the extent practicable, provide information to physicians and groups of physicians about the quality of care furnished by the physician or group of physicians to individuals enrolled under the Medicare program to individuals involved in the rule-making process during 2013 for the physician fee schedule established under subsection (b).

"(C) Budget neutrality.—The Secretary shall apply the payment modifier established under this subsection for items and services furnished—

"(i) Beginning on January 1, 2015, with respect to specific physicians and groups of physicians identified by the Secretary and, thereafter, beginning not later than January 1, 2017, with respect to all physicians and groups of physicians.

"(2) VALUE.—For purposes of paragraph (1), quality of care shall be evaluated, to the extent practicable, based on a composite of measures of the quality of care furnished by a physician or group of physicians to individuals enrolled under this part, such as measures that reflect health outcomes. Such measures shall be evaluated and adopted as determined appropriate by the Secretary.
(5) SYSTEMS-BASED CARE.—The Secretary shall, as appropriate, apply the payment modifier established under this subsection in a manner that promotes systems-based care.

(6) SUPPORT FOR SPECIAL CIRCUMSTANCES OF CERTAIN PROVIDERS.—In applying the payment modifier under this subsection, the Secretary shall, as appropriate, take into account the special circumstances of physicians or groups of physicians in rural areas and other underserved communities.

(7) APPLICATION.—For purposes of the initial period beginning on January 1, 2015, and ending on December 31, 2016, the term ‘physician’ means a physician (as defined in subsection (d)(1)(B)) as the Secretary determines appropriate.

(8) DEFINITIONS.—For purposes of this subsection:
   (A) Costs.—The term ‘costs’ means expenditures per individual as determined by the Secretary.
   (B) Quality of care.—The term ‘quality of care under paragraph (2), including the establishment of appropriate measures of the quality of care under paragraph (2)(B).
   (C) Dates for implementation of the value-based payment modifier under paragraph (7); and
   (D) The dates for implementation of the value-based payment modifier.
   (E) The specification of the initial performance period and any other performance period under paragraphs (4)(D)(i) and (8)(B), respectively;
   (F) The application of the value-based payment modifier under paragraph (7); and
   (G) The determination of costs under paragraph (8)(A).

SEC. 3008. PAYMENT ADJUSTMENT FOR CONDITIONS ACQUIRED IN HOSPITALS.

(a) In general.—Section 184H of the Social Security Act (42 U.S.C. 1395ww), as amended by subsection (a), is amended by adding at the end the following:

(b) Study and report on expansion of healthier conditions policy to other providers.—

(1) Study.—The Secretary of Health and Human Services shall conduct a study on expansion of healthier conditions policy under subsection (d)(4)(D) of section 1866 of the Social Security Act (42 U.S.C. 1395ww) to payments made to other facilities under the Medicare program under title XVIII of the Social Security Act, including such payments made to inpatient rehabilitation facilities, critical access hospitals, long-term care hospitals, and hospitals excluded from the inpatient prospective payment system under such section, hospital outpatient departments, and other hospitals from the inpatient prospective payment system under such section, skilled nursing facilities, ambulatory surgical centers, and health clinics. Such study shall include an analysis of how such policies could impact quality of patient care, patient safety, and spending under the Medicare program.

(2) Report.—Not later than January 1, 2016, the Secretary shall submit a report containing the results of the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

PART II—NATIONAL STRATEGY TO IMPROVE HEALTH CARE QUALITY

SEC. 3011. NATIONAL STRATEGY.

Title III of the Public Health Service Act (42 U.S.C. 241 et seq.) is amended by adding at the end the following:

(p) ADJUSTMENT TO HOSPITAL PAYMENTS

SEC. 390H. NATIONAL STRATEGY FOR QUALITY IMPROVEMENT IN HEALTH CARE.

(a) Establishment of national strategy.—

(A) General.—The Secretary, through a transparent collaborative process, shall establish a national strategy to improve the delivery of health care services, patient health outcomes, and population health.

(B) Identification of priorities.—

(i) General.—The Secretary shall identify national priorities for improvement in developing the strategy under paragraph (1).

(ii) Requirements.—The Secretary shall ensure that priorities identified under subparagraph (A) will—

(i) have the greatest potential for improving health outcomes and patient-centeredness of health care for all populations, including children and vulnerable populations;

(ii) address gaps in quality, efficiency, comparative effectiveness information, and health outcomes measures and data aggregation techniques;

(iii) improve Federal payment policy to emphasize quality and efficiency; and

(iv) enhance the use of health care data to improve quality, transparency, and outcomes.

(vi) address the health care provided to patients with high-cost chronic diseases;

(vii) improve research and dissemination of strategies and best practices to improve patient safety and reduce medical errors, preventable admissions and readmissions, and health care-associated infections; and

(viii) reduce health disparities across health disparity populations (as defined in section 485E) and geographic areas; and

(ix) address other areas as determined appropriate by the Secretary.

(C) Considerations.—In identifying priorities under subparagraph (A), the Secretary shall take into consideration the recommendations submitted by the entity with jurisdiction over the Social Security Act and other stakeholders.
“(D) Coordination with State agencies.—The Secretary shall collaborate, coordinate, and consult with State agencies responsible for administering the Medicaid program under title XIX of the Social Security Act and the Children’s Health Insurance Program under title XXI of such Act with respect to developing and disseminating strategies, goals, and timetables that are consistent with the national priorities identified under subparagraph (A).

“(b) Strategic Plan.—(1) IN GENERAL.—The national strategy shall include a comprehensive strategic plan to achieve the priorities described in subsection (a).

“(2) REQUIREMENTS.—The strategic plan shall include provisions for addressing, at a minimum, the following:

“(A) Coordination among agencies within the Department, which shall include steps to minimize duplication of efforts and utilization of common quality measures, where available. Such common quality measures shall be measures identified by the Secretary under section 1139A or 1139B of the Social Security Act or endorsed under section 1890 of such Act.

“(B) Agency-specific strategic plans to achieve national priorities.

“(C) Establishment of annual benchmarks for each relevant agency to achieve national priorities.

“(D) A process for regular reporting by the agencies to the Secretary on the implementation of the strategic plan.

“(E) Strategies to align public and private payers with regard to quality and patient safety efforts.

“(F) Incorporating quality improvement and measurement in the strategic plan for health information technology required by the American Recovery and Reinvestment Act of 2009 (Public Law 111–5).

“(c) National Strategy and Updates.—

“(1) IN GENERAL.—The Secretary shall update the national strategy not less than annually. Any such update shall include a review of short- and long-term goals.

“(d) Submission and Availability of National Strategy and Updates.—

“(1) DEADLINE FOR INITIAL SUBMISSION OF NATIONAL STRATEGY.—Not later than January 1, 2011, the Secretary shall submit to the relevant committees of Congress the national strategy described in subsection (a).

“(2) UPDATES.—

“(A) IN GENERAL.—The Secretary shall submit to the relevant committees of Congress an annual update to the strategy described in paragraph (1) and the process used to make such identification.

“(B) INFORMATION SUBMITTED.—Each update submitted under subparagraph (A) shall include—

“(i) a review of the short- and long-term goals of the national strategy and any gaps in such strategy;

“(ii) an analysis of the progress, or lack of progress, toward achieving such goals and any barriers to such progress;

“(iii) the information reported under section 1139A of the Social Security Act, consistent with the reporting requirements of such section; and

“(iv) in the case of an update required to be submitted on or after January 1, 2014, the information reported under section 1139B(a)(6) and 1139B(b)(4) of the Social Security Act, consistent with the reporting requirements of such section.

“(2) COLLECTION OF OTHER REPORTING REQUIREMENTS.—Compliance with the requirements of clauses (iii) and (iv) of subparagraph (B) shall satisfy the reporting requirements of the Secretary under section 1139A(a)(6) and 1139B(b)(4), respectively, of the Social Security Act.

“(e) Health Care Quality Internet Website.—Not later than January 1, 2011, the Secretary shall create an Internet website to make public information regarding—

“(i) the national priorities for health care quality improvement established under subsection (a)(2);

“(ii) the agency-specific strategic plans for health care quality described in subsection (b)(2)(B); and

“(iii) other information, as the Secretary determines to be appropriate.


“(a) In General.—The President shall convene the working group known as the Interagency Working Group on Health Care Quality (referred to in this section as the “Working Group”).

“(b) Goals.—The goals of the Working Group shall be to achieve the following:

“(1) Collaboration, cooperation, and consultation between Federal departments and agencies with respect to developing and disseminating strategies, goals, models, and timetables that are consistent with the national priorities identified under section 1139B(a)(2).

“(2) Avoidance of inefficient duplication of quality improvement efforts and resources, where practicable, and a streamlined process for quality reporting and compliance requirements.

“(3) Assess alignment of quality efforts in the public sector with private sector initiatives.

“(4) THE WORKING GROUP.—

“(A) QUALITY MEASURE.—In this subpart, the term ‘quality measure’ means a standard for assessing the performance and improvement of population health or of health plans, providers of services, and other clinicians in the delivery of health care services.

“(B) IDENTIFICATION OF QUALITY MEASURES.—

“(1) IDENTIFICATION.—The Secretary, in consultation with the Director of the Agency for Healthcare Research and Quality and the Administrator of the Centers for Medicare & Medicaid Services, shall identify, not less than often than triennially, gaps where no quality measures exist and existing quality measures that need improvement, updating, or expansion, consistent with the national strategy under section 1139B(a)(2), to the extent available, for use in Federal health programs. In identifying such gaps and existing quality measures that need improvement, the Secretary shall take into consideration—

“(A) the gaps identified by the entity with a contract under section 1890(a) of the Social Security Act and other stakeholders;

“(b) quality measures identified by the Secretary under section 1139B(a)(2) of the Social Security Act; and

“(C) QUALITY MEASURE.—In this subpart, the term ‘quality measure’ means a standard for assessing the performance and improvement of population health or of health plans, providers of services, and other clinicians in the delivery of health care services.

“(2) PUBLICATION.—The Secretary shall make available to the public on an Internet website a report on any gaps identified under paragraph (1) and the process used to make such identification.

“(3) GRANTS OR CONTRACTS FOR QUALITY MEASURE DEVELOPMENT.—

“(A) IN GENERAL.—The Secretary shall award grants, contracts, or intergovernmental agreements to eligible entities for purposes of developing, improving, updating, or expanding quality measures identified under subsection (b).

“(3) PRIORITIZATION IN THE DEVELOPMENT OF QUALITY MEASURES.—In awarding grants, contracts, or agreements under this subsection, the Secretary shall give priority to the development of quality measures that allow the assessment of—

“(A) health outcomes and functional status of patients;

“(B) the management and coordination of health care across episodes of care, and care transitions for patients across the continuum of providers, health care settings, and health plans.

“(c) Health Care Quality Internet Website.—

“(A) Chair.—The Working Group shall be chaired by the Secretary of Health and Human Services.

“(B) Vice-Chair.—Members of the Working Group, other than the Secretary of Health and Human Services, shall serve as Vice Chair of the Group on a rotating basis, as determined by the Group.

“(c) Report to Congress.—Not later than December 31, 2010, and annually thereafter, the Secretary shall submit to the relevant Committees of Congress, and make public on an Internet website, a report describing the progress and recommendations of the Working Group on meeting the goals described in subsection (b).

“SEC. 3013. Quality Measure Development.

“(a) Public Health Service Act.—Title IX of the Public Health Service Act (42 U.S.C. 291 et seq.) is amended—

“(1) by redesigning part D as part E;

“(2) by redesigning sections 931 through 938 as sections 941 through 948, respectively, in title XIX, in section 949, by striking ‘‘931’’ and inserting ‘‘941’’; and

“(3) by inserting after section 926 the following:

“PART D—Health Care Quality Improvement

“Subpart I—Quality Measure Development

“SEC. 931. Quality Measure Development.

“(a) Quality Measure.—In this subpart, the term ‘quality measure’ means a standard for assessing the performance and improvement of population health or of health plans, providers of services, and other clinicians in the delivery of health care services.

“(b) Identification of Quality Measures.—

“(1) Identification.—The Secretary, in consultation with the Director of the Agency for Healthcare Research and Quality and the Administrator of the Centers for Medicare & Medicaid Services, shall identify, not less than often than triennially, gaps where no quality measures exist and existing quality measures that need improvement, updating, or expansion, consistent with the national strategy under section 390HH, to the extent available, for use in Federal health programs. In identifying such gaps and existing quality measures that need improvement, the Secretary shall take into consideration—

“(A) the gaps identified by the entity with a contract under section 1890(a) of the Social Security Act and other stakeholders;

“(B) quality measures identified by the Secretary under section 1139B(a)(2) of the Social Security Act; and

“(C) quality measures identified through the Medicaid Quality Measurement Program under section 1139B of the Social Security Act.

“(2) Publication.—The Secretary shall make available to the public on an Internet website a report on any gaps identified under paragraph (1) and the process used to make such identification.

“(3) Grants or Contracts for Quality Measure Development.—

“(A) In General.—The Secretary shall award grants, contracts, or intergovernmental agreements to eligible entities for purposes of developing, improving, updating, or expanding quality measures identified under subsection (b).

“(3) Prioritization in the Development of Quality Measures.—In awarding grants, contracts, or agreements under this subsection, the Secretary shall give priority to the development of quality measures that allow the assessment of—

“(A) health outcomes and functional status of patients;

“(B) the management and coordination of health care across episodes of care, and care transitions for patients across the continuum of providers, health care settings, and health plans.

“(c) Health Care Quality Internet Website.—

“(A) Chair.—The Working Group shall be chaired by the Secretary of Health and Human Services.

“(B) Vice-Chair.—Members of the Working Group, other than the Secretary of Health and Human Services, shall serve as Vice Chair of the Group on a rotating basis, as determined by the Group.

“(c) Report to Congress.—Not later than December 31, 2010, and annually thereafter, the Secretary shall submit to the relevant Committees of Congress, and make public on an Internet website, a report describing the progress and recommendations of the Working Group on meeting the goals described in subsection (b).
inform decisionmaking about treatment options, including the use of shared decision-making tools and preference sensitive care (as defined in section 3306); 

(2) the meaningful use of health information technology; 

(E) the safety, effectiveness, patient-centeredness, appropriateness, and timeliness of care; 

(F) the efficiency of care; 

(G) the equity of health services and health disparities across health disparity populations (as defined in section 485E) and geographic areas; 

(H) patient experience and satisfaction; 

(I) the use of innovative strategies and methodologies identified under section 936; and 

(J) other areas determined appropriate by the Secretary. 

(3) ELIGIBLE ENTITIES.—To be eligible for a grant or contract under this subsection, an entity shall— 

(A) have demonstrated expertise and capacity in the development and evaluation of quality measures; 

(B) have adopted procedures to include in the quality measure development process— 

(i) the views of other parties who also will use the quality measures (such as patients, consumers, and health care purchasers); 

(ii) the views of other parties who also will use the quality measures; 

(iii) the views of those providers or payers whose performance will be assessed by the measure; and 

(iv) the views of other parties who also will use the quality measures; 

(C) collaborate with the entity with a contract under section 1890(a) of the Social Security Act and other stakeholders, as practicable, and the Secretary so that quality measures developed by the eligible entity will meet the requirements to be considered for endorsement by the entity with a contract under such section 1890(a); 

(D) have policies regarding governance and conflicts of interest; and 

(E) submit an application to the Secretary at such time and in such manner, as the Secretary may require. 

(4) USE OF FUNDS.—An entity that receives a grant, contract, or agreement under this subsection shall use such award to develop quality measures that meet the following requirements: 

(A) Such measures support requirements required to be reported under the Social Security Act and other stakeholders, as practicable, and in support of gaps and existing quality measures that need improvement, as described in subsection (b)(1)(A). 

(B) Such measures support measures developed under section 1139A of the Social Security Act and the Medicaid Quality Measurement Program under section 1139B of such Act, where applicable. 

(C) To the extent practicable, data on such quality measures is able to be collected using health information technologies. 

(D) Each quality measure is free of charge to users of such measure. 

(E) Each quality measure is publicly available on an Internet website. 

(5) ORGANIZATION ACTIVITIES.—BY THE SECRETARY.—The Secretary may use amounts available under this heading to update test or evaluation, applicable, quality measures endorsed by the entity with a contract under section 1890(a) of the Social Security Act or adopted by the Secretary. 

(6) DETERMINATION OF GRANTS.—The Secretary shall ensure that grants or contracts awarded under this Section are coordinated with grants and contracts awarded under section 1395aaa(b)(5) and 1139B(a)(4) of the Social Security Act. 

(b) SOCIAL SECURITY ACT.—Section 1890A of the Social Security Act is amended, as added by section 3014(b), by striking at the end of such section the following new subsection: 

(4) CONSIDERATION OF MULTI-STAKEHOLDER GROUP INPUT.—In general.—The Secretary shall take into consideration the input from multi-stakeholder groups to develop and evaluate quality measures described in subparagraph (B) of such paragraph. 

(5) RATIONALE FOR USE OF QUALITY MEASURES.—The Secretary shall publish in the Federal Register the rationale for the use of quality measures described in section 1890(b)(7)(B) that have been endorsed by the entity with a contract under section 1890.
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“(6) ASSESSMENT OF IMPACT.—Not later than March 1, 2012, and at least once every three years thereafter, the Secretary shall—

(A) conduct an assessment of the quality impact and measures of endorsed measures described in section 1890(b)(7)(B); and

(B) make such assessment available to the public.

(7) MEASUREMENT OF QUALITY IMPROVEMENT.—"(a) MEASUREMENT PROCEDURES.—The Secretary shall establish guidelines for measuring improvements in quality improvement and quality measures which shall include the following:

(i) The incorporation of such measures, where applicable, in workforce programs, training, or any other program of dissemination determined by the Secretary.

(ii) The dissemination of such quality measures through the national strategy developed under section 399HH of the Public Health Service Act.

(b) EXISTING METHODS.—To the extent practicable, the Secretary shall utilize and expand existing dissemination methods in disseminating quality measures under the process established under paragraph (1).

(c) REVIEW OF QUALITY MEASURES USED BY THE SECRETARY.—"(1) IN GENERAL.—The Secretary shall establish a process for disseminating quality measures used by the Secretary.

(ii) an entity capable of submitting such summary data to a particular population, providers, and such as a disease registry, regional collaboration, health plan collaboration, or other population-wide source; or

(iii) a Federal Indian Health Service program or a health program operated by an Indian tribe (as defined in section 4 of the Indian Health Care Improvement Act);

(B) promote the use of the systems that provide data to improve and coordinate patient care;

(C) support the provision of timely, consistent quality and resource use information to health care providers, and other groups and organizations as appropriate, and such opportunity for providers to correct inaccurate measures; and

(D) agree to report, as determined by the Secretary, measures and results, and summary data for a particular population and providers, such as a disease registry, regional collaboration, health plan collaboration, or other population-wide source; or

(E) The dissemination of such quality measures through the national strategy developed under section 399HH of the Public Health Service Act.

(F) The Secretary shall provide standards for the protection of the security and privacy of patient data.

(G) MATCHING FUNDS.—The Secretary may not award a grant or contract under this section to an entity unless the entity agrees that, with respect to such grant or contract—

(1) the entity will make available (directly or through contributions from other public or private entities) non-Federal contributions in a amount equal to $1 for each $5 of Federal funds provided under the grant or contract.

(2) The Federal Indian Health Service program or health program operated by an Indian tribe (as defined in section 4 of the Indian Health Care Improvement Act);

(3) The dissemination of such quality measures through the national strategy developed under section 399HH of the Public Health Service Act.

(4) The Secretary shall provide standards for the protection of the security and privacy of patient data.

(5) The Secretary may award grants or contracts under this section only to entities that enable summary data that can be integrated and compared across multiple sources.

(6) The Secretary shall consult with the public in accordance with the public reporting process established under section 399J.

(7) CONSISTENT DATA AGGREGATION.—"(a) The Secretary may award grants or contracts under this section only to entities that enable summary data that can be integrated and compared across multiple sources.

(b) The Secretary shall consult with the public in accordance with the public reporting process established under section 399J.

(c) The Secretary may provide standards for the protection of the security and privacy of patient data.

(d) MATCHING FUNDS.—The Secretary may not award a grant or contract under this section to an entity unless the entity agrees that, with respect to such grant or contract—

(A) the entity will make available (directly or through contributions from other public or private entities) non-Federal contributions in a amount equal to $1 for each $5 of Federal funds provided under the grant or contract.

(B) 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.

(e) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for fiscal years 2010 through 2014.

SEC. 399J. ESTABLISHMENT OF CENTER FOR MEDICARE AND MEDICAID INNOVATION.

(a) IN GENERAL.—"(1) The Secretary shall establish the Center for Medicare and Medicaid Innovation (‘‘CMI’’). The purpose of the CMI is to carry out the duties described in this section.

(b) RESPONSIBILITIES.—The CMI shall—

(1) carry out the duties described in this section, to review the design and format of the performance measurement system described in this section by not later than January 1, 2011;

(2) ensure that such collection, aggregation, and analysis systems span an increasingly broad range of patient populations, providers, and geographic areas over time;

(3) develop and enhance the performance measurement system described in this section;

(4) develop a methodology for disseminating the performance measurement system described in this section to entities that make and use the system;

(5) review and analyze performance measurement systems that are in use or under development to determine their comparability and utility;

(6) develop and enhance the performance measurement system described in this section to ensure that such collection, aggregation, and analysis systems span an increasingly broad range of patient populations, providers, and geographic areas over time;

(7) carry out the duties described in this section in consultation with the Centers for Medicare & Medicaid Services Program Management Office and with the National Quality Forum;

(8) ensure that such collection, aggregation, and analysis systems are interoperable with other systems used to improve and coordinate care;

(9) develop and enhance the performance measurement system described in this section to ensure that such collection, aggregation, and analysis systems span an increasingly broad range of patient populations, providers, and geographic areas over time;

(10) review and analyze performance measurement systems that are in use or under development to determine their comparability and utility;

(11) develop and enhance the performance measurement system described in this section to ensure that such collection, aggregation, and analysis systems span an increasingly broad range of patient populations, providers, and geographic areas over time;

(12) carry out the duties described in this section in consultation with the Centers for Medicare & Medicaid Services Program Management Office and with the National Quality Forum;

(13) ensure that such collection, aggregation, and analysis systems are interoperable with other systems used to improve and coordinate care;

(14) develop and enhance the performance measurement system described in this section to ensure that such collection, aggregation, and analysis systems span an increasingly broad range of patient populations, providers, and geographic areas over time;

(15) carry out the duties described in this section in consultation with the Centers for Medicare & Medicaid Services Program Management Office and with the National Quality Forum;

(16) ensure that such collection, aggregation, and analysis systems are interoperable with other systems used to improve and coordinate care;

(17) review and analyze performance measurement systems that are in use or under development to determine their comparability and utility;

(18) develop and enhance the performance measurement system described in this section to ensure that such collection, aggregation, and analysis systems span an increasingly broad range of patient populations, providers, and geographic areas over time;

(19) carry out the duties described in this section in consultation with the Centers for Medicare & Medicaid Services Program Management Office and with the National Quality Forum; and

(20) ensure that such collection, aggregation, and analysis systems are interoperable with other systems used to improve and coordinate care.

(c) CONSULTATION.—The Secretary shall consult with the National Advisory Council on Healthcare Quality and Application of Clinical Practice Guidelines, other relevant Federal agencies, and other organizations and entities as appropriate.

(d) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for fiscal years 2010 through 2014.

SEC. 399A. COLLECTION AND ANALYSIS OF DATA FOR QUALITY AND RESOURCE USE MEASURES.

(a) IN GENERAL.—The Secretary shall—

(1) collect and disseminate data on quality and resource use measures from information systems used to support health care delivery to implement the public reporting of performance measures and any other program of dissemination determined by the Secretary.

(2) make such assessment available to the public.

(3) develop and enhance the performance measurement system described in section 399J, and may award grants or contracts for this purpose.

(4) Definitions.—In this section:

(A) APPLICABLE INDIVIDUAL.—The term ‘‘applicable individual’’ means—

(i) an individual who is entitled to, or enrolled for, benefits under part A of title XVIII or enrolled for benefits under part B of such title; or

(ii) an individual who is eligible for medical assistance under title XIX, under a State plan or waiver; or

(iii) the individual is a recipient of a Federal assistance program.

(B) ELIGIBLE INDIVIDUAL.—The term ‘‘eligible individual’’ means—

(i) an individual who is entitled to, or enrolled for, benefits under part A of title XVIII or enrolled for benefits under part B of such title; or

(ii) an individual who is eligible for medical assistance under title XIX, under a State plan or waiver; or
‘(iii) an individual who meets the criteria of both clauses (i) and (ii).

‘(B) APPLICABLE TITLE.—The term ‘applicable title’ means title XVIII, title XIX, or both.

‘(b) TESTING OF MODELS (PHASE I).—

‘(1) IN GENERAL.—The CMI shall test pay-ment and service delivery models accord-ance with selection criteria under paragraph (2) to determine the effect of applying such models under the applicable title (as defined in subsection (a)(4)(B)) on program expendi-ture and service delivery models in accord-ance with selection criteria under such title and the quality of care received by individuals receiving bene-fit under such title.

‘(2) SELECTION OF MODELS TO BE TESTED.—

‘(A) IN GENERAL.—The Secretary shall select models to be tested from models where the Secretary determines that there is evi-dence that the model addresses a defined population for which there are deficits in care leading to poor clinical outcomes or po-tentially avoidable expenditures. The models selected under the preceding sentence may include the models described in subpara-graph (B).

‘(B) OPPORTUNITIES.—The models de-scribed in this subparagraph are the fol-lowing models:

‘(i) Promoting broad payment and practice reform through provider-led multien-dorcent medical home models for high-need applicable individuals, medical homes that address women’s unique health care needs, and reduce avoidable hospitalization prematic practices away from fee-for-service based reim-bursement and toward comprehensive pay-ment or salary-based payment.

‘(ii) Contracting directly with groups of providers of services and suppliers to pro-mote innovative care delivery models, such as through risk-based comprehensive pay-ment or salary-based payment.

‘(iii) Utilizing geriatric assessments and comprehensive care plans to coordinate the care (including through interdisciplinary teams) of applicable individuals with mul-tiple chronic conditions and at least one of the follow-ing:

‘(I) Inability to perform 2 or more ac-tivities of daily living.

‘(II) Cognitive impairment, including de-mentia.

‘(iv) Promote care coordination between providers of services and suppliers that tran-sition health care providers away from fee-for-service reimbursement and toward salary or capitated payment.

‘(v) Supporting care coordination for early discharge of applicable individuals and in cooperation with interdisciplinary teams.

‘(vi) Promoting improved quality and re-duced cost through collaborative high-quality, low-cost health care institu-tions that is responsible for:

‘(I) developing, documenting, and dissemi-nating best practices and proven care meth-ods;

‘(II) implementing such best practices and proven care methods within such institu-tions to demonstrate further improvements in quality and efficiency; and

‘(III) providing assistance to other health care institutions on how best to employ such best practices and proven care methods to improve health care quality and lower costs.

‘(vii) Facilitating inpatient care, including intensive care, of hospitalized applicable in-dividuals at their local hospital through the use of electronic monitoring by specialists, including intensivists and critical care spe-cialists, based at integrated health systems.

‘(viii) Enhancing access and timely access to outpatient services (such as outpatient physical therapy services) through models that do not require a physi-cian referral prior to the receipt of such ser-vice or be involved in establishing the plan of care for the service, when such ser-vice is furnished by a health professional who has the authority to furnish the service under existing State law.

‘(ix) Establishing comprehensive pay-ments to Healthcare Innovation Zones, con-sisting of groups of providers that include a teaching hospital, physicians, and other clinic-al entities, that, through their structure, operations, and joint-activity deliver a full spectrum of comprehensive and high-quality health services to applicable individuals while also incorporating innovative methods for the clinical training of future health care professionals.

‘(x) Expanding access to care through the use of advanced imaging services (as defined in section 1834(e)(1)(B)) according to the physician’s adherence to appropriate-ness guidelines, the ordering of such ser-vices, as determined in consultation with phys-i-cian specialty groups and other relevant stakeholders.

‘(xi) Implementing medication therapy man-agement services, such as described in section 935 of the Public Health Service Act.

‘(xii) Establishing community-based health teams to support small-practice med-ical homes by assisting the primary care practitioner in chronic care management, in-cluding patient self-management, activities.

‘(xiii) Improving access to care through the use of advanced imaging services (as defined in section 1834(e)(1)(B)) according to the physician’s adherence to appropriate-ness guidelines, the ordering of such ser-vices, as determined in consultation with phys-i-cian specialty groups and other relevant stakeholders.

‘(xiv) Expanding access to care through the use of advanced imaging services (as defined in section 1834(e)(1)(B)) according to the physician’s adherence to appropriate-ness guidelines, the ordering of such ser-vices, as determined in consultation with phys-i-cian specialty groups and other relevant stakeholders.

‘(xv) Promoting improved quality and re-duced cost by developing a collaborative of high-quality, low-cost health care institu-tions that is responsible for:

‘(I) developing, documenting, and dissemi-nating best practices and proven care meth-ods;

‘(II) implementing such best practices and proven care methods within such institu-tions to demonstrate further improvements in quality and efficiency; and

‘(III) providing assistance to other health care institutions on how best to employ such best practices and proven care methods to improve health care quality and lower costs.

‘(xvi) Facilitating inpatient care, including intensive care, of hospitalized applicable in-dividuals at their local hospital through the use of electronic monitoring by specialists, including intensivists and critical care spe-cialists, based at integrated health systems.

‘(xvii) Enhancing access and timely access to outpatient services (such as outpatient physical therapy services) through models that do not require a physi-cian referral prior to the receipt of such ser-vice or be involved in establishing the plan of care for the service, when such ser-vice is furnished by a health professional who has the authority to furnish the service under existing State law.

‘(xviii) Establishing comprehensive pay-ments to Healthcare Innovation Zones, con-sisting of groups of providers that include a teaching hospital, physicians, and other clinic-al entities, that, through their structure, operations, and joint-activity deliver a full spectrum of comprehensive and high-quality health services to applicable individuals while also incorporating innovative methods for the clinical training of future health care professionals.

‘(xix) Expanding access to care through the use of advanced imaging services (as defined in section 1834(e)(1)(B)) according to the physician’s adherence to appropriate-ness guidelines, the ordering of such ser-vices, as determined in consultation with phys-i-cian specialty groups and other relevant stakeholders.

‘(xx) Expanding access to care through the use of advanced imaging services (as defined in section 1834(e)(1)(B)) according to the physician’s adherence to appropriate-ness guidelines, the ordering of such ser-vices, as determined in consultation with phys-i-cian specialty groups and other relevant stakeholders.

‘(xxi) Expanding access to care through the use of advanced imaging services (as defined in section 1834(e)(1)(B)) according to the physician’s adherence to appropriate-ness guidelines, the ordering of such ser-vices, as determined in consultation with phys-i-cian specialty groups and other relevant stakeholders.

‘(xxii) Expanding access to care through the use of advanced imaging services (as defined in section 1834(e)(1)(B)) according to the physician’s adherence to appropriate-ness guidelines, the ordering of such ser-vices, as determined in consultation with phys-i-cian specialty groups and other relevant stakeholders.

‘(xxiii) Expanding access to care through the use of advanced imaging services (as defined in section 1834(e)(1)(B)) according to the physician’s adherence to appropriate-ness guidelines, the ordering of such ser-vices, as determined in consultation with phys-i-cian specialty groups and other relevant stakeholders.

‘(xxiv) Expanding access to care through the use of advanced imaging services (as defined in section 1834(e)(1)(B)) according to the physician’s adherence to appropriate-ness guidelines, the ordering of such ser-vices, as determined in consultation with phys-i-cian specialty groups and other relevant stakeholders.

‘(xxv) Expanding access to care through the use of advanced imaging services (as defined in section 1834(e)(1)(B)) according to the physician’s adherence to appropriate-ness guidelines, the ordering of such ser-vices, as determined in consultation with phys-i-cian specialty groups and other relevant stakeholders.

‘(xxvi) Expanding access to care through the use of advanced imaging services (as defined in section 1834(e)(1)(B)) according to the physician’s adherence to appropriate-ness guidelines, the ordering of such ser-vices, as determined in consultation with phys-i-cian specialty groups and other relevant stakeholders.

‘(xxvii) Expanding access to care through the use of advanced imaging services (as defined in section 1834(e)(1)(B)) according to the physician’s adherence to appropriate-ness guidelines, the ordering of such ser-vices, as determined in consultation with phys-i-cian specialty groups and other relevant stakeholders.

‘(xxviii) Expanding access to care through the use of advanced imaging services (as defined in section 1834(e)(1)(B)) according to the physician’s adherence to appropriate-ness guidelines, the ordering of such ser-vices, as determined in consultation with phys-i-cian specialty groups and other relevant stakeholders.

‘(xxix) Expanding access to care through the use of advanced imaging services (as defined in section 1834(e)(1)(B)) according to the physician’s adherence to appropriate-ness guidelines, the ordering of such ser-vices, as determined in consultation with phys-i-cian specialty groups and other relevant stakeholders.

‘(xxx) Expanding access to care through the use of advanced imaging services (as defined in section 1834(e)(1)(B)) according to the physician’s adherence to appropriate-ness guidelines, the ordering of such ser-vices, as determined in consultation with phys-i-cian specialty groups and other relevant stakeholders.

‘(x) EVALUATION.—

‘(A) IN GENERAL.—The Secretary shall con-duct an evaluation of each model tested under this subsection. Such evaluation shall include an analysis of—

‘(i) the quality of care furnished under the applicable title without reducing the quality of care; or

‘(ii) the changes in spending under the app-licable titles by reason of the model.

‘(B) INFORMATION.—The Secretary shall make the results of each evaluation under this paragraph available to the public in a timely fashion and may establish require-ments for States and other entities partici-pating in the testing of models under this section to collect and report data so that the Secretary determines is necessary to monitor and evaluate such models.

‘(c) EXPANSION OF MODELS (PHASE II).—

‘(1) Taking into account the evaluation under subsection (b)(4), the Secretary may, through rulemaking, expand (including imple-mentation on a nationwide basis) the du-ration and the scope of a model that is being tested under subsection (b) or a demonstra-tion project under section 1866C, to the extent determined appropriate by the Sec-retery.

‘(2) Whether the Secretary determines that such ex-pansion is expected to—

‘(A) reduce spending under applicable title without reducing the quality of care; or

‘(B) improve the quality of care and re-duce spending; and
“(2) The Chief Actuary of the Centers for Medicare & Medicaid Services certifies that such expansion would reduce program spending under applicable titles.

“(d) Determination.—

“(1) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII and of sections 1902(a)(1), 1902(a)(2), 1902(a)(3), 1922, and 1931 of the Social Security Act (42 U.S.C. 1395a(a), as amended by section 8002(b), is amended—

“(1) in paragraph (81), by striking ‘‘and’’ at the end; and

“(2) in paragraph (82), by striking the period at the end and inserting ‘‘; and’’; and

“(3) by inserting after paragraph (82) the following new paragraph:

‘‘(83) The implementation of the payment models specified by the Secretary under section 1115A(c) for implementation on a nationwide basis unless the State demonstrates to the satisfaction of the Secretary that implementation would not be administratively feasible or appropriate to the health care delivery system of the State.’’."

“(e) Determination of duration and scope of a model under subsection (b).—

“(A) The Secretary shall determine the duration and scope of a model under subsection (b) as provided in section (d); and

“(B) The Secretary’s determination shall not be final, but may be modified, extended, or revoked at any time prior to the completion of that model.

“(f) Determination of MINIMUM DURATIONS.—

“(A) The Secretary shall determine the minimum durations for models, as specified in section (d), in consultation with the State agencies responsible for the administration of the Medicaid program in each State.

“(B) The determination of minimum durations for models shall be completed not later than January 1, 2012.

“(g) REPORT TO CONGRESS.—Beginning in fiscal year 2012, and not less than once every other year thereafter, the Secretary shall provide to the Congress a report on activities under this section.

“(h) ELIGIBLE ACOS.—

“(A) ACO professionals in group practice arrangements shall include—

“(i) ACO professionals in group practice arrangements who provide services predominantly to the extent that such professionals treat patients in an accountable care organization.

“(ii) ACO professionals in group practice arrangements who provide services predominantly to the extent that such professionals treat patients in an accountable care organization.

“(B) The ACO shall enter into agreements with such providers with respect to the performance of the functions and services specified under subsection (d).

“(C) The ACO shall provide the Secretary with reports of the savings and quality improvements realized by the ACO as a result of its activities under this section.

“(D) The ACO shall include primary care professionals participating in the ACO as required by section (d).

“(E) The ACO shall provide the Secretary with such information regarding ACO professionals participating in the ACO as the Secretary determines necessary to administer the ACO.

“(F) In addition, the ACO shall provide the Secretary with such information regarding ACO professionals as the Secretary determines necessary to administer the ACO.

“(G) The ACO shall define processes to promote evidence-based medicine and patient engagement, report on quality and outcome data, and coordinate care, such as through the use of telehealth, remote patient monitoring, and other such enabling technologies.

“(H) The ACO shall demonstrate to the Secretary that it meets patient-centered care criteria specified by the Secretary as the use of patient and caregiver assessments or the use of individualized care plans.

“(I) QUALITY AND OTHER REPORTING REQUIREMENTS.—

“(A) In general.—The Secretary shall determine appropriate measures to assess the quality of care furnished by the ACO, such as measures of—

“(i) clinical processes and outcomes;

“(ii) patient and, where practicable, caregiver experience of care; and

“(iii) utilization (such as rates of hospital admissions for ambulatory care sensitive conditions).

“(B) REPORTING REQUIREMENTS.—An ACO shall submit data in a form and manner specified by the Secretary on measures the Secretary determines necessary for the ACO to report in order to evaluate the quality of care furnished by the ACO. Such data may include care transitions across health care settings, including hospital discharge planning, and other such measures specified by the Secretary.

“(C) QUALITY PERFORMANCE STANDARDS.—The Secretary shall establish quality performance standards to assess the quality of care furnished by ACOs. The Secretary shall seek to improve the quality of care furnished by ACOs over time by specifying higher standards, new measures, or both for purposes of assessing such quality of care.

“(D) OTHER REPORTING REQUIREMENTS.—The Secretary may, as the Secretary determines appropriate, incorporate reporting requirements and incentive payments related to specific metrics, such as the Patient Centered Medical Home (PCMH) program, the Medicaid Electronic Health Record (EHR) Incentive Program, the Medicare Electronic Health Record (EHR) Incentive Program, and the Medicare Physician Quality Reporting Initiative (PQRI) under section 1848, including such requirements and such payments related to electronic prescribing, electronic health records, and other similar initiatives under section 1848, and may use alternative criteria than would otherwise apply under such section for determining whether to make such payments. The incentive payments described in the preceding sentence shall not be taken into consideration when calculating any payments otherwise made under subsection (d).

“(E) DURATION OF PAYMENTS UNDER SECTION 1115A THAT INVOLVES SHARED SAVINGS PROGRAMS.—A provider of services or supplier that participates in any of the following shall not be eligible to participate in an ACO under subsection (d) for periods in which the provider participates in an ACO under subsection (d) or in such payments otherwise made under subsection (d)

“(A) A model tested or expanded under section 1115A that involves shared savings
impose an appropriate sanction on the ACO, including termination from the program.

(4) TERMINATION.—The Secretary may terminate an agreement with an ACO if it does not meet quality performance standards established by the Secretary under subsection (b)(3).

(e) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to the program.

(f) WAIVER AUTHORITY.—The Secretary may waive such requirements of sections 1128A and 1128B and title XVIII of this Act as may be necessary to carry out the provisions of this section.

(g) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1899, section 1878, or otherwise of—

(1) the determination of criteria under subsection (a)(1)(B);

(2) the assessment of the quality of care furnished by an ACO and the establishment of performance standards under subsection (b)(3);

(3) the assignment of Medicare fee-for-service beneficiaries to an ACO under subsection (c);

(4) the determination of whether an ACO is eligible for shared savings under subsection (d)(2) and the amount of such shared savings; or

(5) the average benchmark for the ACO under subsection (d)(1)(B);

(6) the percent of shared savings specified by the Secretary under subsection (d)(2) and any limit on the total amount of shared savings established by the Secretary under such subsection; and

(7) the determination of an ACO under subsection (d)(4).

(h) DEFINITIONS.—In this section:

(1) ACO PROFESSIONAL.—The term ‘ACO professional’ means—

(A) a physician (as defined in section 1861(r)); and

(B) a practitioner described in section 1861(b)(18)(C).

(2) HOSPITAL.—The term ‘hospital’ means—

(A) any hospital that is—

(i) an inpatient hospital;

(ii) a hospital that is not an inpatient hospital; or

(iii) a hospital that is, under the Secretary’s regulations, required to maintain a relationship with one or more post-acute care facilities;

(B) a hospital (as defined in section 1861(r));

(C) a hospital (as defined in section 1861(s)); and

(D) a hospital (as defined in section 1861(t)).

(3) DEADLINE FOR IMPLEMENTATION.—The Secretary shall establish the pilot program under this section no later than January 1, 2013.

(4) PROVIDER OF SERVICES.—The term ‘provider of services’ has the meaning given in section 1861(a).

(5) SUPPLIER.—The term ‘supplier’ has the meaning given in section 1861(b).

(6) DEADLINE FOR IMPLEMENTATION.—The Secretary shall establish the pilot program no later than January 1, 2013.

(7) DEVELOPMENTAL PHASE.—

(1) DETERMINATION OF PATIENT ASSESSMENT INSTRUMENT.—The Secretary shall determine which patient assessment instrument (such as the Continuity Assessment Record and Evaluation (CARE) tool) shall be used to evaluate the quality of care furnished by an ACO that is not a hospital setting for purposes of determining the most clinically appropriate site for the provision
of post-acute care to the applicable benefici-

"(2) DEVELOPMENT OF QUALITY MEASURES FOR AN EPISODE OF CARE AND FOR POST-ACUTE CARE.

"(A) IN GENERAL.—The Secretary, in con-
sultation with the Agency for Healthcare Re-
search and Quality and the entity with a con-
tact under section 1890(a) of the Social Secu-
ity Act, shall develop quality measures for use in the pilot program—

"(i) for episodes of care; and

"(ii) for post-acute care.

"(B) SITE-NEUTRAL POST-ACUTE CARE QUAL-
ITY MEASURES.—Any quality measures devel-
oped under subparagraph (A)(ii) shall be site-
neutral.

"(C) COORDINATION WITH QUALITY MEASURE
DEVELOPMENT AND ENDORSEMENT PROCEDURE
S.—The Secretary shall ensure that the de-
velopment of quality measures under sub-
paragraph (A) is done in a manner that is
consistent with the measures developed and
endorsed under sections 1890(c) and 1890A that
are applicable to all post-acute care settings.

"(c) DETAILS.—

"(1) DURATION.—

"(A) IN GENERAL.—The pilot program shall be conducted for a period of 5 years.

"(B) REQUIREMENTS.—The Secretary may extend the duration of the pilot program for
providers of services and suppliers partici-
pating in the pilot program as of the day be-
fore the start of the period described in sub-
paragraph (A), for a period determined appro-
priate by the Secretary, if the Sec-

"(A) IN GENERAL.—Subject to subparagraph
(B), the pilot program shall be conducted for a period of 5 years.

"(B) REQUIREMENTS.—The Secretary shall de-
velop requirements for entities partici-
pating in the pilot program as of the day be-
fore the start of the period described in sub-
paragraph (A), for a period determined appro-
priate by the Secretary, if the Sec-

"(A) IN GENERAL.—An entity comprised of
providers of services and suppliers, including a
hospital, a physician group, a skilled nurs-
ing facility, and a home health agency, who
are otherwise participating under this title,
may submit an application to the Secretary to
provide payments to applicable individuals un-
der this section.

"(B) REQUIREMENTS.—The Secretary shall de-
velop requirements for entities to partici-
pate in the pilot program under this sub-
paragraph. Such requirements shall ensure that ap-
plicable beneficiaries have an adequate choice of
providers of services and suppliers under the
pilot program.

"(3) PAYMENT METHODOLOGY.—

"(A) IN GENERAL.—An entity comprised of
providers of services and suppliers, including a
hospital, a physician group, a skilled nurs-
ing facility, and a home health agency, who
are otherwise participating under this title,
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may submit an application to the Secretary to
provide payments to applicable individuals un-
der this section.

"(B) REQUIREMENTS.—The Secretary shall de-
velop requirements for entities to partici-
pate in the pilot program under this sub-
paragraph. Such requirements shall ensure that ap-
plicable beneficiaries have an adequate choice of
providers of services and suppliers under the
pilot program.

"INDEPENDENCE AT HOME DEM-
ONSTRATION PROGRAM.

Title XVIII of the Social Security Act is
amended by inserting after section 1866D, as
inserted by section 3023, the following new
section:

"SEC. 3024. INDEPENDENCE AT HOME DEM-
ONSTRATION PROGRAM.

"(1) IN GENERAL.—Not later than January 1, 2016, the Secretary shall submit a plan for
implementing an expansion of the pilot pro-
gram if the Secretary determines that such expansion will result in improving or not reducing the quality of patient care and reducing spending under this title.

"(2) PARTICIPATING PROVIDERS OF SERVICES AND SUPPLIES.

"(A) IN GENERAL.—An entity comprised of
providers of services and suppliers, including a
hospital, a physician group, a skilled nurs-
ing facility, and a home health agency, who
are otherwise participating under this title,
may submit an application to the Secretary to
provide payments to applicable individuals un-
der this section.

"(B) REQUIREMENTS.—The Secretary shall de-
velop requirements for entities to partici-
pate in the pilot program under this sub-
paragraph. Such requirements shall ensure that ap-
plicable beneficiaries have an adequate choice of
providers of services and suppliers under the
pilot program.

"(3) PAYMENT METHODOLOGY.—

"(A) IN GENERAL.—An entity comprised of
providers of services and suppliers, including a
hospital, a physician group, a skilled nurs-
ing facility, and a home health agency, who
are otherwise participating under this title,
may submit an application to the Secretary to
provide payments to applicable individuals un-
der this section.

"(B) REQUIREMENTS.—The Secretary shall de-
velop requirements for entities to partici-
pate in the pilot program under this sub-
paragraph. Such requirements shall ensure that ap-
plicable beneficiaries have an adequate choice of
providers of services and suppliers under the
pilot program.
appropriate who have experience providing home-based primary care to applicable beneficiaries, make in-home visits, and are available 24 hours per day, 7 days per week to carry out the care that are required to the individual beneficiary’s chronic conditions and designed to achieve the results in subsection (a).

(ii) is organized at least in part for the purpose of providing physicians’ services;

(iii) has documented experience in providing home-based primary care services to high-cost, chronically ill beneficiaries, as determined appropriate by the Secretary;

(iv) furnishes services to at least 200 applicable beneficiaries (as defined in subsection (d)) during each year of the demonstration program;

(v) has entered into an agreement with the Secretary;

(vi) uses electronic health information systems, remote monitoring, and mobile diagnostic technology; and

(vii) meets such other criteria as the Secretary determines to be appropriate to participate in the demonstration program.

The entity shall report on quality measures (in such form, manner, and frequency as specified by the Secretary, which may be for the group of services furnished to applicable beneficiaries, or both) and report to the Secretary (in a form, manner, and frequency as specified by the Secretary) such data as the Secretary determines appropriate to monitor and evaluate the demonstration program.

(B) PHYSICIAN.—The term ‘physician’ includes, except as the Secretary may otherwise provide, any individual who furnishes services for which payment may be made as physicians’ services and has the medical training and experience (as specified by the Secretary) to provide medical services for which payment may be made in home medical practice. Such an individual may be an active participant in, or leading, a home-based primary care team as part of an independence at home medical practice if—

(A) all the requirements of this section are met;

(B) the nurse practitioner or physician assistant may be, is acting consistent with State law; and

(C) the nurse practitioner or physician assistant has the medical training or experience (as specified by the Secretary) to provide medical services for which payment may be made in home medical practice.

(2) PARTICIPATION OF NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS.—Nothing in this section is intended to prevent a nurse practitioner or physician assistant from participating in, or leading, a home-based primary care team as part of an independence at home medical practice if—

(A) the entity is not organized in a manner which would be—

(i) so consciously related to the entity’s business as to violate section 340G of title 18 or section 1870 of title 42, as applicable;

(ii) so consciously related to the entity’s business as to violate section 1320c of title 42, as applicable;

(iii) in any way consciously related to the entity’s business as to violate section 1320c of title 42, as applicable;

(B) such practice fails to meet quality standards during any year of the demonstration program; or

(C) use electronic medical records, health information technology, and individualized plans of care.

(3) INCLUSION OF PROVIDERS AND PRACTITIONERS.—Nothing in this section is intended to prohibit qualified independence at home medical practices from choosing in-home or community-based practitioners to participate in the demonstration program, other than for payments for items and services covered under this title and applicable beneficiary access to services covered under this title and applicable beneficiary access to services covered under this title and applicable beneficiary access to services covered under this title and applicable beneficiary access to services covered under this title.

(4) QUALITY AND PERFORMANCE STANDARDS.—The Secretary shall develop quality performance standards for independence at home medical practices participating in the demonstration program.

(c) PAYMENT METHODOLOGY.—

(1) ESTABLISHMENT OF TARGET SPENDING LEVEL.—The Secretary shall establish an estimated annual spending target, for the amount the Secretary estimates would have been spent had services not been furnished under this section, for items and services covered under parts A and B furnished to applicable beneficiaries for each qualifying independence at home medical practice.

Such spending targets shall be determined on a per capita basis. Such spending targets shall include a risk corridor that takes into account normal variation in expenditures for items and services covered under parts A and B furnished to such beneficiaries with the number of applicable beneficiaries furnished services by each independence at home medical practice. The spending targets may also be adjusted for other factors as the Secretary determines appropriate.

(2) INCENTIVE PAYMENTS.—Subject to performance on quality measures, a qualifying independence at home medical practice is eligible to receive an incentive payment under this section if actual expenditures for a year for the applicable beneficiaries it enrolls are less than the estimated spending target established under paragraph (1) for such year. An incentive payment for such year shall be equal to a portion (as determined by the Secretary) of the amount by which actual expenditures (including incentive payments under this paragraph) for applicable beneficiaries under parts A and B for such year are estimated to be less than 5 percent less than the estimated spending target for such year, as determined under paragraph (1).

(3) APPROPRIATE USE OF INCOME DATA.—

(1) DEFINITION.—In this section, the term ‘applicable beneficiary’ means, with respect to a qualifying independence at home medical practice, an individual who the practice has determined—

(A) is entitled to benefits under part A and enrolled for benefits under part B;

(B) is not enrolled in a Medicare Advantage plan under part C or a PACE program under section 1817;

(C) has 2 or more chronic illnesses, such as congestive heart failure, diabetes, other conditions designated by the Secretary that result in high costs under this title;

(D) within the past 12 months has had a nonacute hospital admission;

(E) within the past 12 months has received acute or subacute rehabilitation services;

(F) has 2 or more functional dependencies requiring the assistance of another person (such as bath dressing, toileting, walking, or feeding); and

(G) meets such other criteria as the Secretary determines appropriate.

(2) PATIENT ELECTED TO PARTICIPATE.—The Secretary shall determine an appropriate method of ensuring that applicable beneficiaries have agreed to enroll in an independence at home medical practice under the demonstration program. Enrollment in the demonstration program shall be voluntary.

(3) BENEFICIARY ACCESS TO SERVICES.—Nothing in this section shall be construed as preventing an independence at home medical practice from including a provider of services or a participating practitioner described in section 1862(b)(1)(C) that is affiliated with the practice under an arrangement structured so that such provider of services or participating practitioner participates in the demonstration program and shares in any savings under the demonstration program.

(4) QUALITY AND PERFORMANCE STANDARDS.—The Secretary shall develop quality performance standards for independence at home medical practices participating in the demonstration program.

(d) IMPLEMENTATION.—

(1) INITIATING DATE.—The demonstration program shall begin no later than January 1, 2012. An agreement with an independence at home medical practice under the demonstration program may cover not more than a 3-year period.

(2) NO PHYSICIAN DUPLICATION IN DEMONSTRATION PARTICIPATION.—The Secretary shall terminate an agreement with an independence at home medical practice under this section that participates in section 1899.

(3) NO BENEFICIARY DUPLICATION IN DEMONSTRATION PARTICIPATION.—The Secretary shall ensure that no applicable beneficiary enrolled in an independence at home medical practice under this section is enrolled in an independence at home medical practice participating in the programs under section 1899.

(4) PREFERENCE.—In approving an independence at home medical practice, the Secretary shall give preference to practices that demonstrate the ability of such practice to improve the quality of health care services provided to applicable beneficiaries.

(5) LIMITATION ON NUMBER OF PRACTICES.—In selecting qualified independence at home medical practices to participate under the demonstration program, the Secretary shall limit the number of such practices so that the number of applicable beneficiaries that may participate in the demonstration program does not exceed 10,000.

(6) WAIVER.—The Secretary may waive such provisions of this title and title XI as the Secretary determines necessary in order to implement the demonstration program.

(7) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to this section.

(e) EVALUATION AND MONITORING.—

(1) IN GENERAL.—The Secretary shall evaluate such independence at home medical practice under the demonstration program to assess whether the practice achieved the results described in subsection (a).

(2) MONITORING APPLICABLE BENEFICIARIES.—The Secretary may monitor data on expenditures and quality of services under this title that an applicable beneficiary receives through participation in a demonstration program, other than for payments for items and services covered under this title, applicable beneficiary access to services, and the quality of health care services provided to applicable beneficiaries.

(3) FUNDING.—For purposes of administering and carrying out the demonstration program, other than for payments for items and services furnished under this title and incentive payments under subsection (c), in addition to funds otherwise appropriated, there shall be transferred to the Secretary for the Center for Medicare & Medicaid Services Program Management Account from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1811 (in proportion to the amounts appropriated by the Secretary) $5,000,000 for each of fiscal years 2010 through 2015. Amounts transferred under this subsection for any fiscal year shall be available until expended.

(f) TERMINATION.—

(1) MANDATORY TERMINATION.—The Secretary shall terminate an agreement with an independence at home medical practice if—

(A) the Secretary estimates or determines that such practice will not receive an incentive payment under the second of 2 consecutive years under the demonstration program; or

(B) such practice fails to meet quality standards during any year of the demonstration program.

(2) PERMISSIVE TERMINATION.—The Secretary may terminate an agreement with an independence at home medical practice if—

(A) the Secretary estimates or determines that such practice will not receive an incentive payment under the second of 2 consecutive years under the demonstration program; or

(B) such practice fails to meet quality standards during any year of the demonstration program.

(3) NO BENEFICIARY DUPLICATION IN DEMONSTRATION PARTICIPATION.—The Secretary shall ensure that no applicable beneficiary enrolled in an independence at home medical practice under this section is enrolled in an independence at home medical practice participating in the programs under section 1899.
(a) In general.—Section 1886 of the Social Security Act (42 U.S.C. 1395ww), as amended by sections 3001 and 3008, is amended by adding at the end the following new subsection:

"(q) Hospital Readmissions Reduction Program.—

"(1) In general.—With respect to payment for discharges from an applicable hospital (as defined in paragraph (5)(C)), occurring during a fiscal year beginning on or after October 1, 2012, in order to account for excess readmissions in the hospital, the Secretary shall determine that would otherwise be made to such hospital under subsection (d) (or section 1814(b)(3), as the case may be) for such a discharge by an amount equal to the product of—

"(I) the base operating DRG payment amount (as defined in paragraph (2) for the discharge); and

"(II) the adjustment factor (described in paragraph (5)(A)) for the hospital for the fiscal year.

"(2) Base operating DRG payment amount defined.—

"(A) In general.—Except as provided in subparagraph (B), in this subsection, the term 'base operating DRG payment amount' means, with respect to a hospital for a fiscal year—

"(i) the payment amount that would otherwise be made under subsection (d) (determined without regard to subsection (o)) for a discharge if this subsection did not apply; reduced by

"(II) any portion of such payment amount that is attributable to payments under paragraphs (5)(A), (5)(B), (5)(F), and (12) of subsection (d).

"(B) Special rules for certain hospitals.—

"(i) Sole community hospitals and Medicare-dependent, small rural hospitals.—In the case of a Medicare-dependent, small rural hospital (with respect to discharges occurring during fiscal years 2012 and 2013) or a sole community hospital, in applying subparagraph (A)(i), the payment amount that would otherwise be made under subsection (d) shall be determined without regard to subparagraphs (I) and (L) of subsection (b)(3) and subparagraphs (D) and (G) of subsection (d)(5).

"(ii) Hospitals paid under section 1844.—In the case of a hospital that is paid under section 1844 of this title, the Secretary may exempt such hospitals provided that States paid under such section submit an annual report to the Secretary describing how a similar reporting mechanism for such hospitals is provided that is consistent with such a methodology.

"(3) Adjustment factor.—

"(A) In general.—For purposes of paragraphs (1), the adjustment factor under this paragraph for a fiscal year is equal to the greater of—

"(i) the ratio described in subparagraph (B) for the hospital for the applicable period (as defined in paragraph (5)(D)) for such fiscal year; or

"(ii) the floor adjustment factor specified in subparagraph (C).

"(B) The floor adjustment factor specified in subparagraph (C).—The floor adjustment factor described in this subparagraph for a hospital for an applicable period is equal to 1 minus the ratio of—

"(I) the aggregate payments for excess readmissions (as defined in paragraph (4)(A)) with respect to such applicable hospital for such applicable period; and

"(ii) the aggregate payments for all discharges (as defined in paragraph (4)(B)) with respect to such applicable hospital for such applicable period.

"(C) Floor adjustment factor.—For purposes of subparagraph (A), the floor adjustment factor specified in this subparagraph for—

"(i) fiscal year 2013 is 0.99; or

"(ii) fiscal year 2014 is 0.98; or

"(iii) fiscal year 2015 and subsequent fiscal years is 0.97.

"(4) Aggregate payments, excess readmission ratio defined.—For purposes of this subsection:

"(A) Aggregate payments for excess readmissions.—The term 'aggregate payments for excess readmissions' means, for a hospital for an applicable period, the sum, for all discharges (as defined in paragraph (5)(A)), of the product, for each applicable condition, of—

"(i) the base operating DRG payment amount for such hospital for such applicable period for such condition; and

"(ii) the number of admissions for such condition for such hospital for such applicable period; and

"(iii) the excess readmissions ratio (as defined in subparagraph (C)) for such hospital for such applicable period minus 1.

"(B) Special rules for certain hospitals.—

"(i) Aggregate payments for all discharges.—The term 'aggregate payments for all discharges, for a hospital for an applicable period, the sum of the base operating DRG payment amount for all discharges for all conditions for such hospital for such applicable period.

"(C) Excess readmission ratio.—

"(i) In general.—Subject to clause (ii), the term 'excess readmissions ratio' means, with respect to an applicable condition for a hospital for an applicable period, the ratio (but not less than 1) of—

"(I) the risk adjusted readmissions based on actual readmissions, as determined consistent with a readmission measure methodology that has been endorsed under paragraphs (5)(A), (5)(B), (5)(G), and (12) of subsection (d); and

"(ii) the risk expected readmissions (as determined consistent with such a methodology) for such hospital for such condition with respect to such applicable period; to

"(ii) the risk adjusted readmissions (as defined consistent with such a methodology) for such hospital for such condition with respect to such applicable period.

"(D) Including excess readmissions ratio under DRG payment amounts.—In the case of a hospital for an applicable period, the ratio (but not less than 1) of—

"(i) the aggregate payments for excess readmissions (as defined in paragraph (4)(A)) for an applicable hospital, the floor adjustment factor under this paragraph, for each applicable condition for such hospital for such applicable period; and

"(ii) the floor adjustment factor (described in paragraph (5)(A)) for such hospital for such applicable condition, for the applicable period and such hospital.

"(5) Definitions.—For purposes of this section:

"(A) Applicable condition.—The term 'applicable condition' means, subject to subparagraph (B), a condition or procedure selected by the Secretary for which a feasible and practical measure has been identified by the Medicare Payment Advisory Commission in its report to Congress in June 2007 and to other conditions and procedures as determined appropriate by the Secretary in expanding such applicable conditions, the Secretary shall seek the endorsement described in subparagraph (A)(ii)(B) but may apply such measures without such an endorsement in the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has been identified by the CMS Hospital Compare website.

"(B) Applicable hospital.—The term 'applicable hospital' means a subsection (d) hospital or a hospital that is paid under section 1814(b)(3), as the case may be.

"(C) Applicable period.—The term 'applicable period' means, with respect to a fiscal year, such period as the Secretary shall specify.

"(D) Readmission.—The term 'readmission' means, in the case of an individual who is discharged from an applicable hospital, the admission of the individual to the same or another applicable hospital within a time period specified by the Secretary for which an applicable hospital relates to an applicable condition for which there is an endorsed measure described in subparagraph (A)(ii)(B), such time period (such as 30 days) shall be consistent with the time period specified for such measure.

"(E) Reporting hospital specific information.—

"(A) In general.—The Secretary shall make information available to the public regarding readmission rates of each subsection (d) hospital under the program.

"(B) Opportunity to review and submit corrections.—The Secretary shall ensure that a subsection (d) hospital has the opportunity to review and submit corrections for the information to be made public with respect to the hospital under subparagraph (A) prior to such information being made public.

"(C) Weights and applicable conditions under paragraph (5).—Such information shall be posted on the Hospital Compare Internet website in an easily understandable format.

"(D) No administrative or judicial review.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the following:

"(i) The determination of base operating DRG payment amounts.

"(ii) The methodology for determining the adjustment factor under paragraph (3), including excess readmissions ratios under paragraph (4)(C), aggregate payments for excess readmissions under paragraph (4)(A), and aggregate payments for all discharges under paragraph (4)(B) for periods and applicable conditions under paragraph (5).

"(E) The measures of readmissions as described in subparagraph (A)(ii)(B).

"(F) Report readmission rates for all patients.—

"(A) In general.—The Secretary shall calculate readmission rates for all patients (as defined in subparagraph (D)) for a specified hospital (as defined in subparagraph (D)(ii)) for an applicable condition and applicable period, or adopted by a consensus organization identified by the Secretary.

"(B) Calculation of readmission rates.—The Secretary shall calculate readmission rates for all patients (as defined in paragraph (4)) for a specified hospital (as defined in paragraph (4)(D)) as the case may be, for an applicable condition and applicable period, or adopted by a consensus organization identified by the Secretary. If the Secretary determines that a hospital has the opportunity to review and submit corrections for the information to be made public with respect to the hospital under subparagraph (A) prior to such information being made public. Such information shall be posted on the Hospital Compare Internet website in an easily understandable format. There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the following:

"(i) The determination of base operating DRG payment amounts.

"(ii) The methodology for determining the adjustment factor under paragraph (3), including excess readmissions ratios under paragraph (4)(C), aggregate payments for excess readmissions under paragraph (4)(A), and aggregate payments for all discharges under paragraph (4)(B) for periods and applicable conditions under paragraph (5).

"(D) Reporting hospital specific information.—

"(A) In general.—The Secretary shall make information available to the public regarding readmission rates of each subsection (d) hospital under the program.

"(B) Opportunity to review and submit corrections.—The Secretary shall ensure that a subsection (d) hospital has the opportunity to review and submit corrections for the information to be made public with respect to the hospital under subparagraph (A) prior to such information being made public.

"(C) Weights and applicable conditions under paragraph (5).—Such information shall be posted on the Hospital Compare Internet website in an easily understandable format.

"(D) No administrative or judicial review.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the following:

"(i) The determination of base operating DRG payment amounts.

"(ii) The methodology for determining the adjustment factor under paragraph (3), including excess readmissions ratios under paragraph (4)(C), aggregate payments for excess readmissions under paragraph (4)(A), and aggregate payments for all discharges under paragraph (4)(B) for periods and applicable conditions under paragraph (5).

"(E) The measures of readmissions as described in subparagraph (A)(ii)(B).
"(B) Postin g of hospital specific all pa- tient readmission rates.—The Secretary shall make information on all patient readmission rates calculated under subparagraph (A) available on the CMS Hospital Compare website in a form and manner determined appropriate by the Secretary. The Secretary may also make other information determined appropriate by the Secretary available on such website.

"(C) Hospital submission of all patient data.—"(1) Except as provided for in clause (ii), each specified hospital (as defined in subparagraph (D)(ii)) shall submit to the Secretary, at the times and in the form and manner specified by the Secretary, data and information determined necessary by the Secretary for the Secretary to calculate the all patient readmission rates described in subparagraph (A).

"(ii) Instead of a specified hospital submitting to the Secretary the data and information described in clause (i), such data and information may be submitted to the Sec- retary, on behalf of such a specified hospital, by a state or an entity determined appropriate by the Secretary.

Definitions.—For purposes of this paragraph:

"(i) The term ‘all patients’ means patients who are treated on an inpatient basis and discharged from a specified hospital (as de- fined in clause (ii)).

"(ii) The term ‘specified hospital’ means a hospital (as defined in section 1886(q)(8)(A) of the Social Security Act) that mines has a high rate of risk adjusted readmission rates for the conditions described in section 1886(q)(8)(A) of the Social Security Act, as added by section 3025.

"(A) Subsection (d) (hospital (as defined in section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)) identified by the Secretary as having a high readmission rate, calculated under section 1886(q) of the Social Security Act, as added by section 3025.

"(B) An appropriate community-based orga- nization that provides care transition services under this section across a continuum of care through arrangements with subsection (d) hospitals (as so defined) to furnish the services described in subsection (c)(2)(B)(i) and includes sufficient coordination of care that includes representation of multiple health care stake- holders (including consumers).

"(ii) Hospital selection and review.—The term ‘high-risk Medicare beneficiary’ means a Medicare beneficiary who has at- tained a minimum hierarchical condition categories score, as determined by the Sec- retary, based on a diagnosis of multiple chronic conditions or other risk factors asso- ciated with a hospital readmission or sub- standard transition into post-hospitalization care, which may include 1 or more of the follow- ing:

(A) Cognitive impairment.

(B) Depression.

(C) A history of multiple readmissions.

(D) Any other chronic disease or risk fac- tor as determined by the Secretary.

"(C) Medicare beneficiaries.—The term ‘Medicare beneficiaries’ means the Medicare beneficiaries (including consumers) and whose governing body includes sufficient representation of multiple health care stake- holders.

"(D) Definitions.—For purposes of this title III of the Public Health Service Act, as amended by section 3025, is further amended by adding at the end the following:

"SEC. 399KK. QUALITY IMPROVEMENT PROGRAM FOR HOSPITALS WITH A HIGH SE- verity Adjusted Readmission Rate.

"(a) Establishment.—In general.—Not later than 2 years after the date of enactment of this section, the Secretary shall make available a program for eligible hospitals to improve their readmission rates through the use of patient safety organizations (as defined in section 921(4)).

"(b) Eligible hospital defined.—In this subsection, the term ‘eligible hospital’ means a hospital that the Secretary deter- mines has a high rate of risk adjusted re- admission rates for the conditions described in section 1886(q)(8)(A) of the Social Security Act and has not taken appropriate steps to reduce such readmissions and improve pa- tient safety as evidenced through histori- cally high rates of readmissions, as deter- mined by the Secretary.

"(3) Risk adjustment.—The Secretary shall establish and implement risk adjustment measures to determine eligible hospitals.

"(c) Report to the Secretary.—As deter- mined appropriate by the Secretary, eligible hospitals and patient safety organizations working with those hospitals shall report to the Secretary on the processes employed by the hospitals to reduce readmissions and the impact of such processes on readmis- sion rates.

SEC. 3026. COMMUNITY-BASED CARE TRANSITION PROGRAM.

(a) In General.—The Secretary shall es- tablish a Community-Based Care Transition Program under which the Secretary provides funding to eligible entities that furnish im- proved care transition services to high-risk Medicare beneficiaries.

(b) Eligibility.—In this section:

(1) Eligible entity.—The term ‘eligible entity’ means the following:

(A) Subsection (d) (hospital (as defined in section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)) identified by the Secretary as having a high readmission rate, calculated under section 1886(q) of the Social Security Act, as added by section 3025.

(B) An appropriate community-based orga- nization that provides care transition services under this section across a continuum of care through arrangements with subsection (d) hospitals (as so defined) to furnish the services described in subsection (c)(2)(B)(i) and includes sufficient coordination of care that includes representation of multiple health care stake- holders (including consumers).

(1) Application.—An eligible entity seek- ing to participate in the program shall submit an application at such time, in such manner, and containing such information as the Secretary may require.

(2) Partnership.—If an eligible entity is a hospital, the Secretary shall enter into a partnership with a community-based organi- zation to participate in the program.

(3) Intention.—Subject to subsection (C), an application submitted under subparagraph (A)(1) shall include a de- tailed proposal for at least 1 care transition intervention, which may include the fol- lowing:

(i) Initiating care transition services for a high-risk Medicare beneficiary not later than 24 hours prior to the discharge of the beneficiary.

(ii) Arranging timely post-discharge fol- low-up services to the high-risk Medicare beneficiary to provide the beneficiary (and, as appropriate, the primary caregiver of the beneficiary) with assistance to ensure productive and timely interactions between patients and post-acute and out- patient providers.

(iii) Assessing and actively engaging with a high-risk Medicare beneficiary (and, as appro- priate, the primary caregiver of the bene- ficiary) through the provision of self-man- agement support and relevant information that is specific to the beneficiary’s condi- tion.

(iv) Conducting comprehensive medication reviews and management services appro- priate, counseling and self-management sup- port.

(4) LIMITATION.—A care transition interven- tion proposed under subparagraph (B) may not include payment for services re- quired under the discharge planning process described in section 1861(ee) of the Social Security Act (42 U.S.C. 1395xx).

(2) Selection.—In selecting eligible enti- ties to participate in the program, the Sec- retary shall give priority to eligible entities that:

(A) participate in a program administered by the Administration on Aging to provide concurrent care transitions interventions with multiple hospitals and practitioners; or

(B) provide services to medically under- served populations, small communities, and rural areas.

(3) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary may implement the provisions of this section by program instruction or otherwise.

(4) Waiver Authority.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act as may be necessary to carry out this section.

(5) Funding.—For purposes of carrying out this section, the Secretary of Health and Human Services shall provide for the trans- fer, from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395f) and the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395e), in such proportion as the Sec- retary determines appropriate, of

$2,000,000,000, to the Centers for Medicare & Medicaid Services Program Management Account for the period of fiscal years 2011 through 2015. Amounts transferred under the preceding sentence shall remain available until expended.

SEC. 3027. EXTENSION OF GAINSHARING DEM- ONSTRATION.

(a) In General.—Subsection (d)(3) of section 5007 of the Deficit Reduction Act of 2005 (Public Law 109-17) is amended by inserting “and for car- ing March 31, 2010, in the case of a demo- stration project in operation as of October 1, 2008” after “December 31, 2009”.

(b) Funding.—In general.—Subsection (f)(1) of such section is amended by striking “2010” and inserting “2014 or until expired”.

(c) Reports.—QUALITY IMPROVEMENT AND SAVINGS.—Subsection (e)(3) of such section is amended by striking “December 1, 2008” and inserting “March 31, 2011”.

(d) Final Report.—Subsection (e)(4) of such section is amended by striking “May 1, 2010” and inserting “March 31, 2013”.

November 19, 2009
PART I—ENSURING BENEFICIARY ACCESS TO PHYSICIAN CARE AND OTHER SERVICES.

SEC. 3101. INCREASE IN THE PHYSICIAN PAYMENT UPDATE.
Section 1848(d) of the Social Security Act (42 U.S.C. 1395w–4(d)) is amended by striking "before January 1, 2010" and inserting "before January 1, 2011." 

SEC. 3102. EXTENSION OF THE WORK GEOGRAPHIC INDEX FLOOR AND REVISIONS TO THE PRACTICE EXPENSE GEOGRAPHIC ADJUSTMENT UNDER THE PHYSICIAN FEESCHEDULE.

(a) EXTENSION OF WORK GPCI FLOOR.—Section 1848(e)(1) of the Social Security Act (42 U.S.C. 1395w–4(e)(1)) is amended—
(1) in subparagraph (A), by striking "2007, and for" and inserting "2009, and 2010";
(2) in subparagraph (B), by striking "December 31, 2009" and inserting "December 31, 2010";
(3) in subparagraph (C)(ii), by striking "December 31, 2009" and inserting "December 31, 2010"; and
(4) by striking "and subparagraph:"

(b) PRACTICE EXPENSE GEOGRAPHIC ADJUSTMENT FOR 2010 AND SUBSEQUENT YEARS.—Section 1848(e)(1) of the Social Security Act (42 U.S.C. 1395w–4(e)(1)) is amended—
(1) in subparagraph (A), by striking "and (G)" and inserting "(G), and (H)"; and
(2) by adding at the end the following new subparagraph:

"(II) the Secretary may apply to such area for such services furnished on or after January 1, 2011, the employee wage and rent portions of the practice expense geographic index described in subparagraph (A)(i) shall reflect 3/4 of the difference between the relative costs of employee wages and rents in each of the different fee schedule areas and the national average of such employee wages and rents." 

SEC. 3103. EXTENSION OF THE WORK GEOGRAPHIC INDEX FLOOR AND REVISIONS TO THE PRACTICE EXPENSE GEOGRAPHIC ADJUSTMENT UNDER THE PHYSICIAN FEESCHEDULE.

(a) EXTENSION OF WORK GPCI FLOOR.—Section 1848(e)(1) of the Social Security Act (42 U.S.C. 1395w–4(e)(1)) is amended by striking "before January 1, 2010" and inserting "before January 1, 2011." 

(b) PRACTICE EXPENSE GEOGRAPHIC ADJUSTMENT FOR 2010 AND SUBSEQUENT YEARS.—Section 1848(e)(1) of the Social Security Act (42 U.S.C. 1395w–4(e)(1)) is amended—
(1) in subparagraph (A), by striking "and (G)" and inserting "(G), and (H)"; and
(2) by adding at the end the following new subparagraph:

"(II) the Secretary may apply to such area for such services furnished on or after January 1, 2011, the employee wage and rent portions of the practice expense geographic index described in subparagraph (A)(i) shall reflect 3/4 of the difference between the relative costs of employee wages and rents in each of the different fee schedule areas and the national average of such employee wages and rents." 

SEC. 3104. EXTENSION OF PAYMENT FOR TECHNICAL SERVICE PROVIDERS OF CERTAIN PHYSICIAN PATHOLOGY SERVICES.

Section 1833(g)(5) of the Social Security Act (42 U.S.C. 1395l(g)(5)) is amended—
(1) by striking "2007, and for" and inserting "2009, and 2010"; and
(2) by striking "December 31, 2009" and inserting "December 31, 2010".

SEC. 3105. EXTENSION OF AMBULANCE ADD-ONS.

(a) GENERAL AMBULANCE.—Section 1834(l)(13)(A) of the Social Security Act (42 U.S.C. 1395m(l)(13)(A)) is amended—
(1) in subparagraph (A), by striking "2007, and for" and inserting "2009, and 2010";
(2) in subparagraph (B), by striking "December 31, 2009" and inserting "December 31, 2010"; and
(3) by adding at the end the following new subparagraph:

"(II) the Secretary may apply to such area for such services furnished on or after January 1, 2011, the employee wage and rent portions of the practice expense geographic index described in subparagraph (A)(i) shall reflect 3/4 of the difference between the relative costs of employee wages and rents in each of the different fee schedule areas and the national average of such employee wages and rents." 

(b) SUPER RURAL AMBULANCE.—Section 1834(l)(13)(A) of the Social Security Act (42 U.S.C. 1395m(l)(13)(A)) is amended—
(1) in subparagraph (A), by striking "2007, and for" and inserting "2009, and 2010";
(2) in subparagraph (B), by striking "December 31, 2009" and inserting "December 31, 2010";
(3) by adding at the end the following new subparagraph:

"(II) the Secretary may apply to such area for such services furnished on or after January 1, 2011, the employee wage and rent portions of the practice expense geographic index described in subparagraph (A)(i) shall reflect 3/4 of the difference between the relative costs of employee wages and rents in each of the different fee schedule areas and the national average of such employee wages and rents." 

SEC. 3106. EXTENSION OF CERTAIN PAYMENT RULES FOR LONG-TERM CARE HOSPITALS AND CERTAIN HOSPITALS AND FACILITIES ON THE ESTABLISHMENT OF CERTAIN HOSPITALS AND FACILITIES.

(a) EXTENSION OF CERTAIN PAYMENT RULES.—Section 114(c) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (42 U.S.C. 1395ww note), as amended by section 1402(a) of the American Recovery and Reinvestment Act (Public Law 111–5), is amended by striking "December 31, 2009" and inserting "December 31, 2010".

(b) EXTENSION OF CERTAIN PAYMENT RULES.—Section 114(d)(1) of such Act (42 U.S.C. 1395ww note), in the matter preceding subparagraph (A), is amended by striking "3-year period" and inserting "4-year period".
years, 3 fiscal years, or other yearly period specified by the Secretary.

"(2) The pharmacy has been enrolled under section 1866(j) as a supplier of durable medical equipment, orthotics, prosthetics, supplies, and related services, has been issued (which may include the renewal of) a provider number for at least 5 years, and for which a final adverse action has not been taken (section 241.575(a)(1)(ii) of title 42, Code of Federal Regulations) has not been imposed in the past 5 years.

"(3) The pharmacy submits to the Secretary an attestation, in a form and manner, and at a time, specified by the Secretary, that the pharmacy meets the criteria described in subclauses (1) and (2). Such attestation shall be subject to section 1001 of title 18, United States Code.

"(IV) The pharmacy agrees to submit materials as requested by the Secretary, or during the course of an audit conducted on a random sample of pharmacies selected annually, to verify that the pharmacy meets the criteria described in subclauses (1) and (II).

Materials submitted under the preceding sentence shall include a certification by an accountant on behalf of the pharmacy or the submission of tax returns filed by the pharmacy for the relevant tax periods, as requested by the Secretary.

"(b) ADMINISTRATION.—Notwithstanding any other provision of law, the Secretary shall implement the amendments made by subsection (a) by program instruction or otherwise.

"(c) RULE OF CONSTRUCTION.—Nothing in the provisions or amendments made by this section shall be construed as affecting the application of an accreditation requirement for pharmacies to qualify for bidding in a competitive acquisition area under section 1847 of the Social Security Act (42 U.S.C. 1395w–3).

SEC. 3110. PART B SPECIAL ENROLLMENT PERIOD FOR DISABLED TRICARE BENEFICIARIES.

(a) IN GENERAL.—

"(1) IN GENERAL.—Section 1837 of the Social Security Act (42 U.S.C. 1395p) is amended by adding at the end the following new subsection:

"(I) In the case of any individual who is a covered beneficiary (as defined in section 1072(b) of title 10, United States Code) at the time of the initial enrollment period, or at any time during such period, there shall be a special enrollment period described in paragraph (2).

"(2) The special enrollment period described in paragraph (1) with respect to an individual is the 12-month period beginning on the day after the last day of the initial enrollment period of the individual or, if later, the first day of the month in which the individual is notified of enrollment under this section.

"(3) In the case of an individual who enrolls during the special enrollment period provided under paragraph (1), the coverage period under this part shall begin on the first day of the month in which the individual enrolls, or: (i) the first day of the individual's initial enrollment period;

"(ii) if the individual is a patient of a hospital on the day the individual is enrolled under this section, the coverage period shall begin on the first day of the month in which the individual is notified of enrollment under this section.

(b) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary may make such regulations as are necessary to carry out the provisions of this section.

SEC. 3111. PAYMENT FOR BONE DENSITY TESTS.

(a) PAYMENT.—

"(1) PAYMENT.—Section 1841 of the Social Security Act (42 U.S.C. 1395w–3) is amended—

(i) in paragraph (4)(B), by inserting ‘‘(V) The pharmacy agrees to submit materials as requested by the Secretary, or during the course of an audit conducted on a random sample of pharmacies selected annually, to verify that the pharmacy meets the criteria described in subclauses (1) and (II). Such attestation shall be subject to section 1001 of title 18, United States Code.’’;

(ii) in subsection (b)(6), by striking ‘‘(V) subsection (b)(6) shall not be taken as applying to an alternative test having equivalent performance characteristics;’’;

(iii) by inserting at the end the following new paragraph:

‘‘(V) TREATMENT OF BONE MASS SCANS.—For dual-energy x-ray absorptiometry services (identified in 2006 by HCPCS codes 76075 and 76077 (and any succeeding codes) furnished during 2010 and 2011, instead of the payment amount that otherwise would be determined under this section for such years, the payment amount shall be 70 percent of the product of—

‘‘(A) the relative value for the service (as determined in subsection (c)(2) for 2006);

‘‘(B) the conversion factor (established under subsection (d) for 2006); and

‘‘(C) the geographic adjustment factor (established under subsection (e)(2)) for the service for the fee schedule area for 2010 and 2011, respectively.’’; and

(b) STUDY AND REPORT BY THE INSTITUTE OF MEDICINE.—

"(1) IN GENERAL.—The Secretary shall conduct a demonstration project under this section for the 2-year period beginning on July 1, 2011.

"(2) STUDY AND REPORT.—The Secretary shall submit to Congress a report containing the results of the study conducted under such paragraph.


Section 1908(b)(1)(A) of the Social Security Act (42 U.S.C. 1395ll(i)) is amended by striking ‘‘$22,290,000,000’’ and inserting ‘‘$30’’.

SEC. 3113. TREATMENT OF CERTAIN COMPLEX DIAGNOSTIC LABORATORY TESTS.

(a) DEMONSTRATION PROJECT.—

"(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ‘‘Secretary’’) shall conduct a demonstration project under part B title XVIII of the Social Security Act under which separate payments are made under such part for certain diagnostic laboratory services provided to individuals under such part. Under the demonstration project, the Secretary shall establish appropriate payment rates for such tests.

(b) COVERED COMPLEX DIAGNOSTIC LABORATORY TEST DEFINED.—In this section, the term ‘‘covered complex diagnostic laboratory test’’ means a diagnostic laboratory test—

(A) that is an analysis of gene protein expression, topographic genotyping, or a cancer chemotherapy sensitivity assay;

(B) that is determined by the Secretary to be a laboratory test for which there is not an alternative test having equivalent performance characteristics;

(C) that is billed using a Health Care Procedure Coding System (HCPCS) code other than a not otherwise classified code under such Coding System;

(D) that is approved or cleared by the Food and Drug Administration or is covered under title XVIII of the Social Security Act; and

(E) is described in section 1816(a)(3) of the Social Security Act (42 U.S.C. 1395r(a)(3)).

"(2) SEPARATE PAYMENT DEFINED.—In this section, the term ‘‘separate payment’’ means a direct payment to a laboratory (including a hospital-based or independent laboratory) that performs a complex diagnostic laboratory test with respect to a specimen collected from an individual during a period in which the individual is a patient of a hospital if the test is performed after such period of hospitalization and if separate payment would not otherwise be made under title XVIII of the Social Security Act by reason of sections 1862(a)(14) and 1866(a)(1)(H)(i) of the such Act (42 U.S.C. 1395y(a)(14); 42 U.S.C. 1395cc(a)(1)(H)(i)).

"(3) DURATION.—Subject to subsection (c)(2), the Secretary shall conduct the demonstration project under this section for the 2-year period beginning on July 1, 2011.

"(c) PAYMENTS AND LIMITATION.—Payments under the demonstration project under this section shall—

(1) be made from funds in the Federal Supplemental Medical Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1395l); and

(2) may not exceed $100,000,000.

"(d) REPORT.—Not later than 2 years after the completion of the demonstration project, the Secretary shall submit to Congress a report on the project. Such report shall include—

(A) an assessment of the impact of the demonstration project on access to care, quality of care, health outcomes, and expenditures under title XVIII of the Social Security Act (including any savings under such title); and

(B) any recommendations as the Secretary determines appropriate.

"(e) IMPLEMENTATION FUNDING.—For purposes of administering this section (including the demonstration project under subsection (d)), the Secretary shall provide for the transfer, from the Federal...
Supplemental Medical Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1395t), to the Centers for Medicare & Medicaid Services Program Management Account, until such amounts transferred under the preceding sentence shall remain available until expended.

SEC. 3114. IMPROVED ACCESS FOR CERTIFIED PUBLIC SERVICES

Section 1833(a)(1)(K) of the Social Security Act (42 U.S.C. 1395i(a)(1)(K)) is amended by inserting “(or 100 percent for services furnished on or before January 1, 2011)” after “1992, 65 percent”.

PART II—RURAL PROTECTIONS

SEC. 3115. EXTENSION OF OUTPATIENT HOLD HARMLESS PROVISION.

(a) IN GENERAL.—Section 1833(b)(7)(D)(i) of the Social Security Act (42 U.S.C. 1395l(c)(7)(D)(i)) is amended—

(1) in subclause (II)—

(A) in the first sentence, by striking “2010” and inserting “2011”;

(B) in the second sentence, by striking “or 2009” and inserting “, 2009, or 2010”;

and (2) in subclause (III), by striking “January 1, 2010” and inserting “January 1, 2011”.

(b) PERMITTING ALL SOLE COMMUNITY HOSPITALS TO BE ELIGIBLE FOR HOLD HARMLESS.—Section 1833(b)(7)(D)(ii)(III) of the Social Security Act (42 U.S.C. 1395l(c)(7)(D)(ii)(III)) is amended by adding at the end the following new sentence: “In the case of covered OPI services furnished on or after January 1, 2011, the term ‘1-year extension period’ begins on the last day of the initial 5-year period, the Secretary shall conduct the demonstration program under this section as if the last day of the initial 5-year period, the Secretary shall conduct the demonstration program during the 1-year extension period unless the rural community hospital makes an election, in such form and manner as the Secretary may prescribe, to discontinue such participation.”

(c) TECHNICAL AMENDMENTS.—Section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2272) is amended by adding at the end the following new sentence: “(in this section referred to as ‘the initial 5-year period’) that begins on or after January 1, 2011” after “5-year period’”.

(d) HARMLESS PROVISION.

(3) INCREASE IN MAXIMUM NUMBER OF HOSPITALS PARTICIPATING IN THE DEMONSTRATION PROGRAM.—Notwithstanding subsection (a)(4), during the 1-year extension period, not more than 30 rural community hospitals may participate in the demonstration program under this section.

(4) No Eligible Hospitals in Demonstration Program on Date of enactment.—In the case of a rural community hospital that is participating in the demonstration program during the 1-year extension period unless the rural community hospital makes an election, in such form and manner as the Secretary may prescribe, to discontinue such participation, (a) 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) is amended by inserting “(in this section referred to as the ‘initial 5-year period’) and, as provided in subsection (g), for the 1-year extension period after ‘5-year period’.”

SEC. 3116. EXTENSION OF MEDICARE REASONABLE COSTS PAYMENTS FOR CERTAIN CLINICAL DIAGNOSTIC LABORATORY TESTS FURNISHED TO HOSPITALIZED PATIENTS IN CERTAIN RURAL AREAS.

Section 416(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (42 U.S.C. 1395l–4, as amended by section 105 of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395l–6.001 note) and section 107 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (42 U.S.C. 1395l–6)), is amended by adding at the end the following new subsection:

“(g) ONE-YEAR EXTENSION OF DEMONSTRATION PROGRAM.—

(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary shall conduct the demonstration program under this section for an additional 1-year period (in this section referred to as the ‘1-year extension period’) that begins on the date immediately following the last day of the initial 5-year period under subsection (a)(5).

(2) EXPANSION OF DEMONSTRATION STATES.—Notwithstanding subsection (a)(2), during the 1-year extension period, the Secretary shall expand the number of States with low population densities determined by the Secretary under such subsection to 20. In determining which States to include in such expansion, the Secretary shall use the same criteria and data that the Secretary used to determine the States under such subsection for purposes of the initial 5-year period.

(3) EXPANSION OF DEMONSTRATION HOSPITALS PARTICIPATING IN THE DEMONSTRATION PROGRAM.—Notwithstanding subsection (a)(4), during the 1-year extension period, not more than 30 rural community hospitals may participate in the demonstration program under this section.

(4) No Eligible Hospitals in Demonstration Program on Date of enactment.—In the case of a rural community hospital that is participating in the demonstration program during the 1-year extension period unless the rural community hospital makes an election, in such form and manner as the Secretary may prescribe, to discontinue such participation, (a) REMOVAL OF LIMITATION ON NUMBER OF ELIGIBLE COUNTRIES SELECTED.—Section 416(a)(3) of section 123 of the Medicare Improvements for Patients and Providers Act of 2008 (42 U.S.C. 1395k–4 note) is amended by striking “more than 6”.

(b) REMOVAL OF REFERENCES TO RURAL HEALTH CLINIC SERVICES AND INCLUSION OF PHYSICIANS’ SERVICES IN SCOPE OF DEMONSTRATION PROJECT.—Such section 123 is amended—

(1) in subsection (d)(4)(B)(3), by striking subclause (III); and

(2) in subsection (j)—

(A) in paragraph (8), by striking subparagraph (B) and inserting the following:

“(B) Physicians’ services (as defined in section 1395x(g) of the Social Security Act (42 U.S.C. 1395x(g)))”;

(B) by striking paragraph (9); and

(C) by redesignating paragraph (10) as paragraph (9).

SEC. 3117. MEDPAC STUDY ON ADEQUACY OF MEDICARE PAYMENTS FOR HEALTH SERVICES SERVING IN RURAL AREAS.

(a) STUDY.—The Medicare Payment Advisory Commission shall conduct a study on the adequacy of payments for services and items and services furnished by providers of services and suppliers in rural areas under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.). Such study shall include an analysis of—

(1) any adjustments in payments to providers of services and suppliers that furnish items and services in rural areas;

(2) access by Medicare beneficiaries to items and services in rural areas;

(3) the adequacy of payments to providers of services and suppliers that furnish items and services in rural areas; and

(4) the quality of care furnished in rural areas.

(b) REPORT.—Not later than January 1, 2011, the Medicare Payment Advisory Commission shall submit to Congress a report containing recommendations on appropriate modifications to any adjustments in payments to providers of services and suppliers that furnish items and services in rural areas, together with recommendations for such legislation and administrative actions as the Medicare Payment Advisory Commission determines appropriate.

SEC. 3128. TECHNICAL CORRECTION RELATED TO CRITICAL ACCESS HOSPITAL SERVICES.

(a) IN GENERAL.—Subsections (g)(2)(A) and (b)(8) of section 1834 of the Social Security Act

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Act (42 U.S.C. 1395m) are each amended by inserting “101 percent of” before “the reasonable costs”.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect as if included in the enactment of section 405(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 177).

SEC. 3120. EXTENSION OF AND REVISIONS TO MEDIcare RURAL HOSPITAL FLEXIBILITY PROGRAM.

(a) AUTHORIZATION.—Section 3302(c)(2) of the Social Security Act (42 U.S.C. 1395f–4(i)(5)) is amended—

(1) by striking “2010, and before January 1, 2010, and before January 1, 2016, 3 percent”;

(2) in subsection (a)—

(A) by striking “, and episodes” and inserting “, and visits”;

(B) in paragraph (4), by striking “, and for purposes of providing care to individuals who are dually eligible for Medicare and Medicaid, for purposes of national pilot program on payment bundling under section 1866D, and other delivery system reform programs determined appropriate by the Secretary” before the period at the end; and

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to grants made on or after January 1, 2010.

PART III—IMPROVING PAYMENT ACCURACY

SEC. 3121. PAYMENT ADJUSTMENTS FOR HOME HEALTH CARE.

(a) REBASING HOME HEALTH PROSPECTIVE PAYMENT AMOUNT.—

(1) in paragraph (5)(A) of section 1833(b)(3)(A) of the Social Security Act (42 U.S.C. 1395fff(b)(3)(A)) is amended—

(A) in clause (1)(III), by striking “For periods ending on or after April 1, 2010, and before January 1, 2011”;

(B) in clause (1)(IV) and inserting “Subject to clause (III), for periods”; and

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

“(III) ADJUSTMENT FOR 2013 AND SUBSEQUENT YEARS.—

“(I) IN GENERAL.—Subject to subclause (II), for 2013 and subsequent years, the amount (or amounts) that would otherwise be applicable under clause (I)(II) shall be adjusted by a percentage determined appropriate by the Secretary to reflect such factors as—

(A) the study conducted under this subsection for the period.

(b) USE OF FUNDS.—Section 1832(c)(3) of the Social Security Act (42 U.S.C. 1395f–4(g)(3)) is amended—

(1) by striking “2010, and before January 1, 2010, and before January 1, 2016, 3 percent”;

(2) in subsection (a)—

(A) by striking “, and episodes” and inserting “, and visits”;

(B) by inserting “, and for purposes of providing care to individuals who are dually eligible for Medicare and Medicaid, for purposes of national pilot program on payment bundling under section 1866D, and other delivery system reform programs determined appropriate by the Secretary” before the period at the end; and

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to grants made on or after January 1, 2010.

ORDER TO ENSURE ACCESS TO CARE AND QUALITY SERVICES.

SEC. 3131. PAYMENT ADJUSTMENTS FOR HOME HEALTH SERVICES.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall conduct a study to evaluate the costs and quality of care among efficient home health agencies relative to other such agencies in providing on-site access to care and in treating Medicare beneficiaries with varying severity levels of illness. Such study shall include an analysis of the following:

(A) Methods to revise the home health prospective payment system under section 1885 of the Social Security Act (42 U.S.C. 1395fff) to more accurately reflect the costs related to patient severity of illness or to improving beneficiary access to care, including—

1. payment adjustments for services that may be under- or over-valued;

2. necessary changes to reflect the resource use relative to providing home health services to low-income Medicare beneficiaries or Medicare beneficiaries living in medically underserved areas;

3. ways the outlier payment may be improved to more accurately reflect the cost of treating Medicare beneficiaries with high severity levels of illness;

4. the role of quality of care incentives and other initiatives in reducing health care spending times.

(b) USE OF FUNDS.—Section 1866D, and other delivery system reforms under the provisions of and amendments made by the Patient Protection and Affordable Care Act, such as value-based purchasing programs, accountable care organizations under section 1899, the National pilot program on payment bundling under section 1866D, and other delivery system reform programs determined appropriate by the Secretary shall—

1. consult with the Federal and State governments, and other entities, including hospitals, health plans, and other providers of home health care, to develop recommendations with regard to the determination of reimbursement for home health care services, including changes in payment rules, policies, and procedures to support the provision of high-quality care;

2. consult with the OASIS and other data sets and models to measure patient severity of illness; and

3. develop methods to adjust payment rates for home health care services to reflect the costs and quality of care among efficient home health agencies relative to other such agencies in providing on-site access to care and in treating Medicare beneficiaries with varying severity levels of illness.

(c) REPORT.—Not later than March 1, 2011, the Secretary shall submit to Congress a report setting forth recommendations for such legislation and administrative action as the Secretary determines appropriate.

(d) CONSIDERATION.—In conducting the study under paragraphs (1) and (3), the Secretary shall consider whether certain factors should be used to measure patient severity of illness and access to care, such as—

1. population density and relative patient access to care;

2. variations in service costs for providing care to individuals who are dually eligible under the Medicare Advantage program;

3. the presence of severe or chronic diseases, as evidenced by multiple, discontinuous home health episodes;

4. poverty status, as evidenced by the receipt of Supplemental Security Income under title XVI of the Social Security Act;

5. the absence of caregivers;

6. language barriers;

7. atypical transportation costs; and

8. other factors determined appropriate by the Secretary.

3. Report.—Not later than March 1, 2011, the Secretary shall submit to Congress a report on the study conducted under paragraph (1) and preparing the report under paragraph (3), the Secretary shall consult with—
(A) stakeholders representing home health agencies;
(B) groups representing Medicare beneficiaries;
(C) the Medicare Payment Advisory Commission;
(D) the Inspector General of the Department of Health and Human Services; and
(E) the Comptroller General of the United States.

SEC. 3132. HOSPICE REFORM.
(a) Hospice Care Payment Reforms.—
(1) IN GENERAL.—Subtitle D of title XVIII of the Social Security Act (42 U.S.C. 1395w–4(c), as amended by section 3001(c), is amended—
(A) by redesignating paragraph (6) as paragraph (7); and
(B) by inserting after paragraph (5) the following new paragraph:
``(6)(A) The Secretary shall collect additional data and information as the Secretary determines appropriate to revise payments for hospice care under this subsection pursuant to subparagraph (D) and for other purposes as determined appropriate by the Secretary. The Secretary shall begin to collect such data by not later than January 1, 2011.
``(B) The additional data and information to be collected under subparagraph (A) may include:
``(i) charges and payments;
``(ii) the number of days of hospice care which are attributable to individuals who are entitled to, or enrolled for, benefits under part A; and
``(iii) with respect to each type of service included in hospice care, the following: (I) the number of days of hospice care attributable to the type of service; (II) the cost of the type of service; and (III) the amount of payment for the type of service.
``(iv) charitable contributions and other revenue of the hospice program;
``(v) the number of hospice visits; and
``(vi) the type of practitioner providing the visit; and
``(vii) the length of the visit and other basic information with respect to the visit.
``(C) The Secretary may collect the additional data and information under subparagraph (A) on cost reports, claims, or other mechanisms as the Secretary determines to be appropriate.
``(D)(i) Notwithstanding the preceding paragraphs of this subsection, not earlier than October 1, 2013, the Secretary, by regulation, implement revisions to the methodology for determining the payment rates for routine home care and other services included in hospice care furnished under this part, as the Secretary determines to be appropriate.
``(ii) Revisions in payment implemented pursuant to clause (i) shall result in the same estimated amount of aggregate expenditure savings for hospice care furnished in the fiscal year in which such revisions in payment are implemented as would have been made under this title for such care in such fiscal year if such revisions had not been implemented.
``(E) The Secretary shall consult with hospice programs and the Medicare Payment Advisory Commission regarding the additional data and information to be collected under subparagraph (A) and the payment revisions under subparagraph (D).
``(2) AMENDMENTS.—Section 1814(h)(1)(C) of the Social Security Act (42 U.S.C. 1395w–4(h)(1)(C)) is amended—
``(A) in clause (i)—
``(I) in the matter preceding subclause (I), by inserting ``(before the first fiscal year in which the payment revisions described in paragraph (6)(D) are implemented)'' after ``subsequent fiscal year''; and
``(ii) in subclause (VII), by inserting ``(before the first fiscal year in which the payment revisions described in paragraph (6)(D) are implemented), subject to clause (iv),'' after ``subsequent fiscal year''; and
``(B) by adding at the end the following new clause:
````(ii) With respect to routine home care and other services included in hospice care furnished during fiscal years subsequent to the first fiscal year in which payment revisions described in paragraph (6)(D) are implemented, the market basket percentage increase (as defined in section 1886(b)(3)(B)(iii)) for the fiscal year.
````(b) Adoption of medpac hospice program eligibility certification requirements.—Section 1814(a)(7) of the Social Security Act (42 U.S.C. 1395f(a)(7)) is amended—
``(1) in subparagraph (B), by striking ``(3)'' and
``(2) in paragraph (1), by striking ``(3)'' and
``(2) by amending the following new subparagraph:
````(D) on and after January 1, 2011—
``````(i) a hospice physician or nurse practitioner has a face-to-face encounter with the individual to determine continued eligibility of the individual for hospice care prior to the 180th-day recertification and each subsequent recertification under subparagraph (A)(ii) and attests that such visit took place (in accordance with procedures established by the Secretary); and
``````(ii) in the case of hospice care provided an individual for more than 180 days by a hospice program for which the number of such cases for such program comprises more than a percent (specified by the Secretary) of the total number of such cases for all programs under this title, the hospice care provided to such individual is medically reviewed (in accordance with procedures established by the Secretary); and
``(3) limitations on review.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the following:
````(A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).
````(B) Any period selected by the Secretary for such purposes.
``(c) Misvalued Codes Under the Physician Fee Schedule.
(1) In General.—Section 1848 of the Social Security Act (42 U.S.C. 1395w–4(c), as amended by sections 3001, 3008, and 3025, is amended—
``(1) in subparagraph (A)(i), by striking ``(C)'' and
``(2) by adding at the end the following new subparagraph:
````(F) Payments to subsection (d) hospitals for the fiscal year, the Secretary shall pay to the subsection (d) hospital 25 percent of such amount (which represents the empirically justified amount for such payment, as determined by the Medicare Payment Advisory Commission in its March 2007 Report to the Congress).
````(2) ADDITIONAL PAYMENT.—In addition to the payment made to a subsection (d) hospital under paragraph (1), for fiscal years 2015 and each subsequent fiscal year, the Secretary shall pay to the subsection (d) hospital an additional amount equal to the product of the following factors:
````(I) a factor determined by the Secretary equal to 1 minus the percent change (which represents the empirically justified amount for such payment, as determined by the Medicare Payment Advisory Commission in its March 2007 Report to the Congress).
````(2) ADDITIONAL PAYMENTS.—For each fiscal year 2015, 2016, and 2017, the amount equal to 1 minus the percent change (divided by 100) in the percent of individuals under the age of 65 who are uninsured, as determined by comparing the percent of such individuals—
````(I) who are uninsured in 2012, the last year before coverage expansion under the Patient Protection and Affordable Care Act (as calculated by the Secretary based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on such Act that, if determined in the affirmative, would clear such Act for enrollment); and
````(II) who are uninsured in the most recent period for which data is available (as so calculated).
````(3) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the following:
````(A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).
````(B) Any period selected by the Secretary for such purposes.
``(2) In General.—Section 1848(c)(2)(B) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)(B)) is amended by adding at the end the following new paragraph:
````(C) Potentially Misvalued Codes.—
``````(1) IN GENERAL.—The Secretary shall—
````````(i) periodically identify services as being potentially misvalued using criteria specified in clause (ii); and
````````(ii) review and make appropriate adjustments to the relative values established under paragraph (1) for services identified as being potentially misvalued under subsection (b).
"(II) IDENTIFICATION OF POTENTIALLY MISVALUED CODES.—For purposes of identifying potentially misvalued services pursuant to clause (i), the Secretary shall examine, and if the Secretary determines to be appropriate (and families of codes as appropriate) for which there has been the fastest growth, codes (and families of codes as appropriate) determined to be appropriate, and family codes (and families of codes as appropriate) determined to be appropriate by the Secretary, the relative value units assigned to such services; and the methodology to be used in determining appropriate adjustments to the fee schedule under subsection (b). The provisions of subparagraph (B)(ii)(II) shall apply to adjustments to relative value units made pursuant to this subparagraph in the same manner as such provisions applied to adjustments under subparagraph (B)(ii)(II)."

"(b) IMPLEMENTATION.—

(1) ADMINISTRATION.—

(A) In Title 44, United States Code and the provisions of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to this section or the amendment made by this section.

(B) Notwithstanding any other provision of law, the Secretary may implement subparagraphs (K) and (L) of 1840c(c)(2) of the Social Security Act, section 4085 of the Balanced Budget Act of 1997, or subsection (a), by program instruction or otherwise.

"(2) FOCUSING CMS RESOURCES ON POTENTIALLY OVERVALUED CODES.—Section 1886(a) of the Social Security Act (42 U.S.C. 1395w–4(a)) is repealed.

SEC. 3135. MODIFICATION OF EQUIPMENT UTILIZATION FACTOR FOR ADVANCED IMAGING SERVICES.

(a) ADJUSTMENT IN PRACTICE EXPENSE TO REFLECT HIGHER PRESUMED UTILIZATION.—

Section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended—

(i) in subsection (b)(4)—

(A) in subparagraph (B), by striking "subparagraph (A)" and inserting "this paragraph"; and

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

"(C) ADJUSTMENT IN PRACTICE EXPENSE TO REFLECT HIGHER PRESUMED UTILIZATION.—Consistent with the methodology for computing the number of practice expense relative value units under subsection (c)(2)(C) with respect to advanced diagnostic imaging services (as defined in section 1834(i)(1)(B)) furnished on or after January 1, 2010, the Secretary shall adjust such number of units so it reflects—

"(i) in the case of services furnished on or after January 1, 2010, and before January 1, 2013, a 65 percent (rather than 50 percent) presumed rate of utilization of imaging equipment; and

(ii) in the case of services furnished on or after January 1, 2013, and before January 1, 2014, a 70 percent (rather than 50 percent) presumed rate of utilization of imaging equipment; and

(iii) in the case of services furnished on or after January 1, 2014, a 75 percent (rather than 50 percent) presumed rate of utilization of imaging equipment.";

and

(ii) by adding the following new subclause:

"(ii) in the case of services furnished beginning with 2014, reduced expenditures attributable to the increase in the multiple procedure payment reduction from 25 to 50 percent (as described in subsection (b)(4)(D))."

(c) ANALYSIS BY THE CHIEF ACTUARY OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES.—Not later than January 1, 2015, the Chief Actuary of the Centers for Medicare & Medicaid Services shall make publicly available an analysis of whether, for the period of 2010 through 2019, the cumulative expenditure reductions under title XVIII of the Social Security Act that are attributable to the adjustments under the amendments made by this section are projected to exceed $3,000,000,000.

SEC. 3136. REVISION OF PAYMENT FOR POWER-DRIVEN WHEELCHAIRS.

(a) IN GENERAL.—Section 1834(a)(7)(A) of the Social Security Act (42 U.S.C. 1395m(a)(7)(A)) is amended—

(1) in clause (1)—

(A) in subparagraph (B), by striking "50 percent", and inserting "50 percent", and

(B) by adding after "Subject to" and "50 percent, respectively.";

and

(2) in clause (2)—

(A) by striking "10 percent", and inserting "15 percent", and

(B) by adding the following new subclause:

"(III) SPECIAL RULE FOR POWER-DRIVEN WHEELCHAIRS.—For purposes of payment for power-driven wheelchairs, clause (II) shall be applied by substituting 15 percent for 10 percent, and 7.5 percent for 7.5 percent, respectively.";

and

(3) in clause (3)—

(A) in the heading, by inserting "complex, rehabilitative", before "power-driven";

and

(B) by inserting "complex, rehabilitative" before "power-driven".

(b) TECHNICAL AMENDMENT.—Section 1834(a)(7)(C)(ii)(II) of the Social Security Act (42 U.S.C. 1395m(a)(7)(C)(ii)(II)) is amended by striking "10 percent" from "10 percent" and "7.5 percent".

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—Subject to paragraph (2), the amendments made by subsection (a) shall apply to power-driven wheelchairs furnished on or after July 1, 2011, and shall apply to power-driven wheelchairs furnished on or after such date.

(2) APPLICATION TO COMPETITIVE BIDDING.—The amendments made by subsection (a) shall not apply to payment made for items and services furnished pursuant to contracts...
entered into under section 1847 of the Social Security Act (42 U.S.C. 1395w–5) prior to January 1, 2011, pursuant to the implementation of subsection (a)(1)(B)(i)(I) of such section 1847.

SEC. 3117. HOSPITAL WAGE INDEX IMPROVEMENT.

(a) EXTENSION OF SECTION 508 HOSPITAL RECLASSIFICATION.


(b) USE OF PARTICULAR WAGE INDEX IN FISCAL YEAR 2010.—For purposes of implementation of the amendment made by this subsection during fiscal year 2010, 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.

(c) AUTHORIZING THE MEDICARE HOSPITAL WAGE INDEX SYSTEM.—

(1) IN GENERAL.—Not later than December 31, 2011, the Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall submit to Congress a report that includes a plan to reform the hospital wage index system under section 1886 of the Social Security Act.

(2) DETAILS.—In developing the plan under paragraph (1), the Secretary shall take into account the goals for reforming such system set forth in the Payment Advisory Commission June 2007 report entitled “Report to Congress: Promoting Greater Efficiency in Medicare”, including establishing a new hospital compensation index system that—

(A) uses Bureau of Labor Statistics data, or other data or methodologies, to calculate relative wages for each geographic area involved;

(B) minimizes wage index adjustments between and within metropolitan statistical areas and statewide rural areas;

(C) includes methods to minimize the volatility of wage index adjustments that result from implementation of policy, while maintaining budget neutrality in applying such adjustments;

(D) takes into account the effect that implementation of the system would have on health care providers and on each region of the country;

(E) addresses issues related to occupational mix, such as staffing practices and ratios, and any evidence on the effect on quality of care or patient safety as a result of the implementation of the system; and

(F) provides for a transition.

SEC. 3118. TREATMENT OF CERTAIN CANCER TREATMENTS.

Section 1833(t) of the Social Security Act (42 U.S.C. 1395(t)) is amended by adding at the end the following new paragraph:

“(b) AUTHORIZATION OF ADJUSTMENT FOR CANCER HOSPITALS.—

“(1) STUDY.—The Secretary shall conduct a study to determine if, under the system, costs incurred by hospitals described in section 1886(d)(1)(B)(v) with respect to ambulatory payment classification groups exceed those costs incurred by other hospitals pursuant to this subsection (as determined appropriate by the Secretary). In conducting the study under this subparagraph, the Secretary shall take into consideration the cost of drugs and biologicals incurred by such hospitals.

“(2) AUTHORIZATION OF ADJUSTMENT.—Insofar as the Secretary determines under subparagraph (A) that costs incurred by other hospitals furnishing services under this subsection (as determined appropriate by the Secretary) exceed those costs incurred by other hospitals furnishing services under this subsection (as determined appropriate by the Secretary), the Secretary for purposes of applying title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) from funds otherwise paid under such title to such hospitals.

“(3) DURATION.—The demonstration program under this section shall be conducted for a 3-year period.

(c) INDEPENDENT EVALUATION AND REPORTS.—

(1) INDEPENDENT EVALUATION.—The Secretary shall provide for an independent evaluation of the demonstration program under this section. Such independent evaluation shall determine whether the demonstration program has improved patient care, quality of life, and cost-effectiveness for Medicare beneficiaries participating in the demonstration program.

(2) REPORTS.—The Secretary shall submit to Congress a report containing the results of the evaluation conducted under paragraph (1), together with such recommendations as the Secretary determines appropriate.

(d) BUDGET NEUTRALITY.—With respect to the 3-year period of the demonstration program under this section, the Secretary shall ensure that the aggregate expenditures under title XVIII for such period shall not exceed the aggregate expenditures that would have been expended under such title if the demonstration program under this section had not been in effect. Such hospital programs shall be located in urban and rural areas.

SEC. 3119. PAYMENT FOR BIOSIMILAR BIOLOGICAL PRODUCTS.

(a) IN GENERAL.—Section 1847A of the Social Security Act (42 U.S.C. 1395ww–sa) is amended—

(1) in subsection (b)—

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

“(8) BIOSIMILAR BIOLOGICAL PRODUCT.—The term ‘biosimilar biological product’ means a biologic product approved under an abbreviated application for a license of a biological product that relies in part on data or information in an application for another biological product licensed under section 351 of the Public Health Service Act.

“(b) USE OF PARTICULAR CRITERIA FOR DETERMINING SIMILARITY.—

(1) IN GENERAL.—The Secretary shall use the uniform, national adjustment to the area wage index.

SEC. 3120. MEDICARE HOSPICE CONCURRENT CARE PROGRAM.

(a) STUDY.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall conduct a study to determine whether payments to Medicare-dependent small rural hospitals under subsection providing for a biosimilar pathway (as determined by the Secretary).

SEC. 3140. MEDICARE HOSPICE CONCURRENT CARE DEMONSTRATION PROGRAM.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall establish a Medicare Hospice Concurrent Care demonstration program at participating hospice programs under which Medicare beneficiaries are enrolled, during hospice care and any other items or services covered under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) from funds otherwise paid under such title to such hospice programs.

(2) DURATION.—The demonstration program under this section shall be conducted for a 3-year period.

(c) INDEPENDENT EVALUATION AND REPORTS.—

(1) INDEPENDENT EVALUATION.—The Secretary shall provide for an independent evaluation of the demonstration program under this section. Such independent evaluation shall determine whether the demonstration program has improved patient care, quality of life, and cost-effectiveness for Medicare beneficiaries participating in the demonstration program.

(2) REPORTS.—The Secretary shall submit to Congress a report containing the results of the evaluation conducted under paragraph (1), together with such recommendations as the Secretary determines appropriate.

(d) BUDGET NEUTRALITY.—With respect to the 3-year period of the demonstration program under this section, the Secretary shall ensure that the aggregate expenditures under title XVIII for such period shall not exceed the aggregate expenditures that would have been expended under such title if the demonstration program under this section had not been in effect. Such hospital programs shall be located in urban and rural areas.

SEC. 3141. APPLICATION OF BUDGET NEUTRALITY ON A NATIONAL BASIS IN THE CALCULATION OF THE MEDICARE HOSPICE WAGE INDEX.

In the case of discharges occurring on or after October 1, 2010, for purposes of applying section 4410 of the Balanced Budget Act of 1997 (42 U.S.C. 1395ww note) and paragraph (b)(3) of section 4225 of the Federal Regulations, the Secretary of Health and Human Services shall administer subsection (b) of such section 4410 and paragraph (c) of such section 4225 in the same manner as the Secretary administered such subsection (b) and paragraph (c) for discharges occurring during fiscal year 2008 (through a uniform, national adjustment to the area wage index).

SEC. 3142. IIHS STUDY ON URBAN MEDICARE-DEPENDENT HOSPITALS.

(a) STUDY.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall conduct a study on the need for an additional payment for urban Medicare-dependent hospitals for inpatient hospital services under section 1886 of the Social Security Act (42 U.S.C. 1395ww). Such study shall include an analysis of—

(A) the Medicare inpatient margins of urban Medicare-dependent hospitals, as determined by the Secretary, that had not received 1 or more additional payments or adjustments under such section (including those payments or adjustments described in paragraph (2)); and

(B) whether payments to Medicare-dependent, small rural hospitals under subsection...
(d)(5)(G) of such section should be applied to urban Medicare-dependent hospitals.

(2) Urban Medicare-dependent hospital defined.—For purposes of this section, the term "urban Medicare-dependent hospital" means a subsection (d) hospital (as defined in subsection (d)(1)(B) of such section) that—

(A) does not receive any additional payment adjustment under such section, such as payments for indirect medical education costs under subsection (d)(5)(B) of such section, disproportionate share payments under subsection (d)(5)(A) of such section, payments to a rural referral center under subsection (d)(5)(C) of such section, payments to a critical access hospital under section 1861(h) of the Social Security Act (42 U.S.C. 1395v(i)), payments to a sole community hospital under subsection (d)(5)(D) of such section 1886, or payments to a medicare-dependent, small rural hospital under subsection (d)(6)(G) of such section 1886; and

(B) for which more than 60 percent of its inpatient days or discharges during 2 of the 3 most recently audited cost reporting periods for which the Secretary has a settled cost report were attributable to inpatients entitled to benefits under part A of title XVIII of the Act.

(b) Report.—Not later than 9 months after the date of enactment of this Act, the Secretary shall submit to Congress a report containing the results of the study conducted under subsection (a), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

Subtitle C—Provisions Relating to Part C

SEC. 2251. MEDICARE ADVANCE PAYMENT.

(a) MA Benchmark Based on Plan’s Competitive Benchmark Amount.—

(1) In general.—Section 1853(j) of the Social Security Act (42 U.S.C. 1395w–27(f)) is amended—

(i) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively, and indenting the clauses appropriately;

(ii) in clause (i), by striking “an amount equal to” and inserting “(i), by striking “paragraph (A)” and inserting “(ii) in clause (i), by striking “an amount equal to” and inserting “(paragraph (A))’’; and

(iii) in clause (ii), by redesignating by striking “(paragraph (A))” and inserting “(paragraph (A))’’.

(2) Report.—Not later than 9 months after the date of enactment of this Act, the Secretary shall submit to Congress a report containing the results of the study conducted under subsection (a), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

Subpart B—Provisions Relating to the Medicare Advantage Program

Subpart C—Provisions Relating to the Medicare Advantage Program

Section 1854(b)(1)(C)(i) of the Social Security Act (42 U.S.C. 1395w–24(b)(1)(C)(i)) is amended—

(i) through the end and inserting ‘‘through 2010’’;

(ii) in paragraph (5), by striking the period at the end and inserting a comma; and

(iii) in clause (v), by adding at the end the following new clauses—

‘‘(v) for 2011, 3 percentage points; and

‘‘(vii) for a year after 2011, 0 percentage points.’’.

(c) Enhancement of Beneficiary Reimbursements.—Section 1854(b)(1)(C)(i) of the Social Security Act (42 U.S.C. 1395w–24(b)(1)(C)(i)) is amended—

(1) by striking ‘‘(v) for 2007 through 2010’’ and inserting ‘‘(v) for 2003 through 2010’’; and

(2) in subsection (d), by striking ‘‘(b)’’ and inserting ‘‘(c)’’.
amounts submitted on or after January 1, 2012.

(e) MA LOCAL PLAN SERVICE AREAS.—
   (1) IN GENERAL.—Section 183(d) of the Social Security Act (42 U.S.C. 1395w–23(d)) is amended
   (A) in the subsection heading, by striking “MA REGION” and inserting “MA REGION; MA LOCAL PLAN SERVICE AREA”;
   (B) in paragraph (1), by striking subparagraph (A) and inserting the following:
   “(A) with respect to an MA local plan—
   (i) for years before 2012, an MA local area (as defined in paragraph (2)); and
   (ii) for 2012 and succeeding years, a service area that is an entire urban or rural area, as applicable (as described in paragraph (5)); and
   (C) by adding at the end the following new paragraph:
   “(5) MA LOCAL PLAN SERVICE AREA.—For 2012 and succeeding years, the service area for an MA local plan shall be an entire urban or rural area in each State as follows:
   "(A) URBAN AREAS.—
   "(i) In general.—Subject to clause (ii) and subparagraph (D), the service area for an MA local plan in an urban area shall be the Core Based Statistical Area (as referred to in subsection (1), by striking “a Medicare Advantage payment area” and inserting “MA local area (as so defined)”;
   "(ii) In the matter preceding subparagraph (A), by striking “(A) Medicare Advantage payment area that is” and inserting “ MA area (as so defined)”;
   "(iii) In section 183(c)(1) of such Act (42 U.S.C. 1395w–23(c)(1))—
   "(I) in the matter preceding subparagraph (A), by striking “a Medicare Advantage payment area that is” and inserting “ MA area (as so defined)”;
   "(ii) in the matter following subparagraph (B), by striking “MA plan that preclude the offering of a Medicare Advantage contract or MA plan level; or
   "(iii) such other care management and coordination programs as the Secretary determines appropriate.
   "(D) CONDUCT OF PROGRAM IN URBAN AND RURAL AREAS.—An MA plan may conduct a performance program described in subparagraph (C) in a manner appropriate for an urban or rural area, as applicable.

(2) CONFORMING ENDS.—
   (A) IN GENERAL.—
   (i) Section 1851(b)(1) of the Social Security Act (42 U.S.C. 1395w–23(b)(1)) is amended by striking "(B) in
   (ii) Section 1851(b)(1)(B)(i) of such Act (42 U.S.C. 1395w–23(b)(1)(B)(i));
   (iii) in the matter preceding clause (1), by striking “MA local area (as defined in section (d)(2))” and
   (iv) in subclause (1), by striking “MA payment area” and inserting “MA local area (as so defined)”;
   (ii) Section 1853(b)(4) of such Act (42 U.S.C. 1395w–23(b)(4)) is amended by striking "(B) and ensure patient-centered, appropriate care.
   "(D) DATA USED IN DETERMINING SCORE.—Each Medicare Advantage organization shall provide to the Secretary the information needed to determine whether they are eligible for a care coordination and performance adjustment under this paragraph. The Secretary shall monitor auditing activities conducted under this subparagraph.
   "(E) QUALITY PERFORMANCE BONUSES.—
   "(A) QUALITY BONUS.—For years beginning with 2014, the Secretary shall, in addition to any other payment provided under this part, make monthly payments, with respect to coverage of an individual under this part, to the MA plan in an amount equal to—
   "(i) the case of a plan that achieves a 3 star rating (or comparable rating) on a rating system described in subparagraph (C) in an amount equal to—
   "(i) the case of a plan that achieves a 3 star rating (or comparable rating) on such system 2 percent of the national monthly per capita cost for expenditures for individuals enrolled under the original Medicare fee-for-service program for the year; and
   "(ii) in the case of a plan that achieves a 4 or 5 star rating (or comparable rating on such system, 4 percent of such national monthly per capita cost for the year; and
   "(B) IMPROVED QUALITY BONUS.—For years beginning with 2014, in the case of an MA plan that does not receive a quality bonus under subparagraph (A) and is an improved quality MA plan with respect to the year (as identified by the Secretary), the Secretary shall, in addition to any other payment provided under this part, make monthly payments, with respect to coverage of an individual under this part, to the MA plan in an amount equal to 1 percent of such national monthly per capita cost for the year.
   "(C) USE OF RATING SYSTEM.—For purposes of subparagraph (A), a rating system described in this paragraph is—
   "(i) a rating system that uses up to 5 stars to rate clinical quality and enrollee satisfaction and performance at the Medicare Advantage contract or MA plan level; or
   "(ii) such other system established by the Secretary that provides for the determination of a comparable quality performance rating to the rating system described in clause (i); and
   "(D) DATA USED IN DETERMINING SCORE.—
   "(i) IN GENERAL.—The rating of an MA plan under the rating system described in subparagraph (C) with respect to the year shall be based on the most recent data available.
“(ii) PLANS THAT FAIL TO REPORT DATA.—An MA plan which does not report data that enables the Secretary to rate the plan for purposes of subparagraph (A) or identify the plan for purposes of subparagraph (B) shall be deemed, for purposes of such rating or identification, as having the lowest plan performance rating and the lowest percentage improvement rate, respectively.

“(3) QUALITY BONUS FOR NEW AND LOW ENROLLMENT MA PLANS.—

“(A) NEW MA PLANS.—For years beginning with 2012, in the case of the first year of an MA plan that first submits a bid under section 1854(a)(1)(A) for 2012 or a subsequent year, only receives rebates under paragraph (2) of section 1886(b) in addition to any other payment provided under this part, make monthly payments, with respect to coverage of an individual under this part, to the MA plan in an amount equal to 2 percent of national monthly per capita cost for expenditures for individuals enrolled under the original Medicare fee-for-service program for the year. For any year in which such an election may be made, the MA plan shall be paid in the same manner as other MA plans with comparable enrollment.

“(B) LOW ENROLLMENT PLANS.—For years beginning with 2012, in the case of such a subparagraph. as applicable, to determine whether the low enrollment provision of this subsection applies to MA regional plans in a similar manner as such performance bonuses apply to MA plans under such subsection.

“(g) GRANDFATHERING SUPPLEMENTAL BENEFITS FOR CURRENT ENROLLERS AFTER IMPLEMENTATION OF COMPETITIVE BIDDING.—Section 1853 of the Social Security Act (42 U.S.C. 1395w–23(a)(1)(B)) is amended—

“(1) IDENTIFICATION OF AREAS.—The Secretary shall identify MA local areas in which, with respect to 2009, average bids submitted by an MA organization under section 1854(a) for MA local plans in the area are not greater than 75 percent of the adjusted average capitation costs for the year involved, determined under section 1876(a)(4), for the area for individuals who are not enrolled in an MA plan under this part for the year, but adjusted to exclude costs attributable to payments under section 1848(b), 1866(d), and 1866(h).

“(2) ELECTION TO PROVIDE REBATES TO GRANDFATHERED ENROLLERS.—In general.—For years beginning with 2012, each Medicare Advantage organization offering an MA local plan in an area identified by the Secretary under paragraph (1) (i) may elect to provide rebates to grandfathered enrollees under section 1854(b)(1)(C). In the case where an MA organization makes such an election, the monthly per capita dollar amount of such rebates shall not exceed the applicable amount for the year (as defined in subparagraph (B)).

“(B) APPLICATION.—For purposes of this subsection, the term ‘applicable amount’ means—

“(i) for 2012, the monthly per capita dollar amount of such rebates provided to enrollees under the MA local plan with respect to 2011; and

“(ii) for a subsequent year, 95 percent of the amount described in clause (i) for the prior calendar year.

“(3) SPECIAL RULES FOR PLANS IN IDENTIFIED AREAS.—Notwithstanding any other provision of this part, the following shall apply with respect to each Medicare Advantage organization offering an MA local plan in an area identified by the Secretary under paragraph (1) (i) that makes an election described in paragraph (2):

“(A) PAYMENTS.—The amount of the monthly payment under this section to the Medicare Advantage organization with respect to coverage of a grandfathered enrollee under this part in the area for a month, shall be equal to—

“(i) for 2012 and 2013, the sum of—

“(I) the bid amount under section 1854(a) for the MA local plan; and

“(II) the applicable amount (as defined in paragraph (2)(B)) for the MA local plan for the year.

“(ii) for 2014 and subsequent years, the sum of—

“(I) the MA competitive benchmark amount under subsection (j)(1)(A)(i) for the area for the month, adjusted, only to the extent the Secretary determines necessary, to take into account the MA organization’s utilization as a result of rebates provided to grandfathered enrollees (except that such adjustment shall not exceed 0.5 percent of such MA competitive benchmark); and

“(II) the applicable amount (as so defined) for the MA local plan for the year.

“(B) REQUIREMENT TO SUBMIT BIDS UNDER COMPETITIVE BIDDING.—The Medicare Advantage organization shall submit a single bid amount under section 1854(a) for the MA local plan and the Medicare Advantage organization shall remove from such bid amount any effects of induced demand for care that may result from the higher rebates available to grandfathered enrollees under this subsection.

“(C) NONAPPLICATION OF BONUS PAYMENTS AND ANY OTHER BONUSES.—The Medicare Advantage organization offering the MA local plan shall not be eligible for any bonus payment under subsection (n) or any rebate payment under paragraph (h) (other than as provided under this subsection) with respect to grandfathered enrollees.

“(D) NONAPPLICATION OF UNIFORM BID AND PAYMENT AMOUNTS TO GRANDFATHERED ENROLLERS.—Section 1854(c)(1) shall not apply with respect to the MA local plan.

“(E) NONAPPLICATION OF LIMITATION ON APPLICATION OF PART B PREMIUM.—Notwithstanding clause (ii) of section 1854(b)(1)(C), in the case of a grandfathered enrollee, a rebate under such section may be used for the purposes described in clause (ii)(III) of such section.

“(F) RISK ADJUSTMENT.—The Secretary shall risk adjust rebates to grandfathered enrollees in the same manner as the Secretary risk adjusts beneficiary rebates described in section 1854(b)(1)(C).

“(4) DEFINITION OF GRANDFATHERED ENROLEE.—In this subsection, the term ‘grandfathered enrollee’ means an individual who is enrolled (effective as of the date of enactment of this subsection) in an MA local plan in an area that is identified by the Secretary under paragraph (1).”

“(o) GRANDFATHERING SUPPLEMENTAL BENEFITS.—Section 1853 of the Social Security Act (42 U.S.C. 1395w–23) is amended—

“(1) IDENTIFICATION OF AREAS.—The Secretary shall provide for the publication of the information described in the previous sentence on the Internet website of the Centers for Medicare & Medicaid Services.

“(B) CONFORMING AMENDMENT.—Section 1886(h) of the Social Security Act (42 U.S.C. 1395w–26(a)(1)(C)) is amended—

“(i) in clause (i), by inserting “and any performance bonus under subsection (n)” before the period at the end; and

“(ii) in clause (ii), by striking “G” and inserting “(G), plus the amount (if any) of any performance bonus under subsection (n)”;

“(2) PERFORMANCE BONUSES TO MA REGIONAL PLANS.—Section 1858 of the Social Security Act (42 U.S.C. 1395w–27a) is amended—

“(A) in subsection (f)(1), by striking “subsection (e)” and inserting “subsections (e) and (f)”; and

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

“(i) APPLICATION OF PERFORMANCE BONUSES TO MA REGIONAL PLANS.—For years beginning with 2014, the Secretary shall apply the performance bonuses under section 1853(n) (relating to bonuses for care coordination and management, quality performance, and risk adjustment for MA regional plans) in a similar manner as such performance bonuses apply to MA plans under such subsection.

“(2) RISK ADJUSTMENT.—The Secretary shall provide for the publication of the information described in the previous sentence on the Internet website of the Centers for Medicare & Medicaid Services.

“(3) APPLICABLE AREAS.—In this subsection, the term ‘applicable area’ means the following:

“(A) The 2 largest metropolitan statistical areas, if the Secretary determines that the total amount of such extra benefits for each enrollee for the month in those areas is greater than $100.

“(B) A county where—

“(i) the MA area-specific non-drug monthly benchmark amount for a month in 2011 is equal to the legacy urban floor amount (as described in subsection (c)(1)(B) (ii)), as determined by the Secretary for the area for 2011; and

“(ii) the percentage of Medicare Advantage eligible beneficiaries in the county who are enrolled in an MA plan for 2011 is greater than 30 percent (as determined by the Secretary); and

“(iii) average bids submitted by an MA organization under section 1854(a) for all local plans in the county for 2011 are not greater than the adjusted average per capita cost for

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the year involved, determined under section 1876(a)(4), for the county for individuals who are not enrolled in an MA plan under this part for the year, but adjusted to exclude costs of transitional rebates under section 1848(b)(6), 1886(n), and 1886(h).

(4) REVIEW OF PLAN BIDS.—In the case of a bid submitted by an MA organization under section 1854(a) for an MA local plan in an applicable area, the Secretary shall review such bid in order to ensure that extra benefits (as specified by the Secretary) are provided under such plan.

(5) FUNDING.—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 established under section 1848 in such proportion as the Secretary determines appropriate, of an amount not to exceed $5,000,000,000 for the period of fiscal years 2012 through 2019 for the purpose of providing transitional rebates under section 1854(b)(1)(C) for the provision of extra benefits under this subsection.

(6) NONAPPLICATION OF COMPETITIVE BIDDING AND RELATED PROVISIONS AND CLARIFICATION OF MA PAYMENT AREA FOR PACE PROGRAMS.—

(a) NONAPPLICATION OF COMPETITIVE BIDDING AND RELATED PROVISIONS FOR PACE PROGRAMS.—Section 1894 of the Social Security Act (42 U.S.C. 1395w–24(b)(1)) is amended—

(1) in clause (i), by inserting “subject to clauses (ii) and (iii)”,

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

“(ii) MA local area (as defined in section 1894, the MA payment area provided to enrollees described in paragraph (2)).”

(b) NONAPPLICATION OF COMPETITIVE BIDDING AND RELATED PROVISIONS UNDER PART A.—Section 1854(b)(1)(C) for the provision of extra benefits under this subsection.

(1) NONAPPLICATION OF COMPETITIVE BIDDING AND RELATED PROVISIONS FOR PACE PROGRAMS.—Section 1852(a)(1)(B) of the Social Security Act (42 U.S.C. 1395w–22(a)(1)(B)) is amended—

(1) by redesignating clauses (iii) and (iv) as clauses (iv) and (v); and

(2) by inserting after clause (iv) the following new clause:

“(v) MA local area (as defined in section 1894, the MA payment area provided to enrollees described in paragraph (2)).”

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to plan years beginning on or after January 1, 2011.

(b) APPLICATION OF REBATES, PERFORMANCE BONUSES, AND PENALTIES.—

(1) APPLICATION OF REBATES.—Section 1854(b)(1)(C) of the Social Security Act (42 U.S.C. 1395w–24(b)(1)(C)) is amended—

(A) in clause (i), by striking “REBATE.—A rebate” and inserting “REBATE FOR PLAN YEARS BEFORE 2012.—For plan years before 2012, a rebate may be used for the purpose described in clause (ii)(III) and shall be provided through the application of the amount of the rebate described in clause (ii)(III) to the payment of the maximum amount that would otherwise be payable for the benefit or service under this section, except that such payments shall be provided only for services that are covered under part C.”;

(B) by redesigning clauses (iii) and (iv) as clauses (iv) and (v); and

(C) by inserting after clause (ii) the following new clause:

“(III) FORM OF REBATE FOR PLAN YEAR 2012 AND SUBSEQUENT PLAN YEARS.—For plan years beginning on or after January 1, 2012, a rebate may be used for the purpose described in clause (ii)(III) and shall be provided through the application of the amount of the rebate described in clause (ii)(III) to the payment of the maximum amount that would otherwise be payable for the benefit or service under this section, except that such payments shall be provided only for services that are covered under part C.”

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to plan years beginning on or after January 1, 2011.

(c) APPLICATION OF MA MONTHLY SUPPLEMENTAL BENEFICIARY PREMIUM.—Section 1854(b)(2)(C) of the Social Security Act (42 U.S.C. 1395w–24(b)(2)(C)) is amended—

(A) by striking “PREMIUM.—The term” and inserting “PREMIUM.—”

(1) IN GENERAL.—The term “

and (B) by adding at the end the following new clause:

“(ii) APPLICATION OF MA MONTHLY SUPPLEMENTAL BENEFICIARY PREMIUM.—For plan years beginning on or after January 1, 2012, any MA monthly supplementary beneficiary premium charged to an individual enrolled in an MA plan shall be used for the purposes, and in the priority order, described in subsection (b) by adding at the end the following new clause:

“(ii) APPLICATION OF MA MONTHLY SUPPLEMENTAL BENEFICIARY PREMIUM.—For plan years beginning on or after January 1, 2012, any MA monthly supplementary beneficiary premium charged to an individual enrolled in an MA plan shall be used for the purposes, and in the priority order, described in subsection (b).

(d) APPLICATION OF CODING INTENSITY ADJUSTMENT FOR 2011 AND SUBSEQUENT YEARS.—

(1) NONAPPLICATION OF COMPETITIVE BIDDING AND RELATED PROVISIONS FOR PACE PROGRAMS.—Section 1852(a)(1)(B) of the Social Security Act (42 U.S.C. 1395w–22(a)(1)(B)) is amended—

(1) by adding at the end the following new clause:

“(C) if the Secretary determines appro-
is amended—

(1) PLAN DESCRIBED.—A plan described in this subclause is a specialized MA plan for special needs individuals described in section 1855(b)(6)(B)(ii) that is fully integrated with capitated contracts with States for Medicaid benefits.

(2) APPLICABILITY.—The Secretary shall apply the payment rules under section 1859(d) (other than paragraph (3) of such section) rather than the payment rules that would otherwise apply under this part, but only to the extent necessary to reflect the costs of treating high concentrations of frail individuals.

(2) PLAN DESCRIBED.—A plan described in this subclause is a specialized MA plan for special needs individuals described in section 1855(b)(6)(B)(ii) that is fully integrated with capitated contracts with States for Medicaid benefits.

(2) PLAN DESCRIBED.—A plan described in this subclause is a specialized MA plan for special needs individuals described in section 1855(b)(6)(B)(ii) that is fully integrated with capitated contracts with States for Medicaid benefits.

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(b) Medicare Coverage Gap Discount Program.—Part D of title XVIII of the Social Security Act (42 U.S.C. 1395w–101) is amended by inserting after section 1860D–14 the following:

“SEC. 1860D–14A. (a) Establishment.—The Secretary shall establish a Medicare coverage gap discount program (in this section referred to as ‘program’) to be in effect no later than July 1, 2010. Under the program, the Secretary shall enter into agreements described in subsection (b) with manufacturers for the provision of discounted prices described in subsection (c)(1). The Secretary shall establish a model agreement for use under the program by not later than April 1, 2010, in consultation with manufacturers, and allow for comment on such model agreement.

(b) Terms of Agreement.—

(1) In General.—

(A) Agreement.—An agreement under this section shall require the manufacturer to provide applicable beneficiaries access to discounted prices for applicable drugs of the manufacturer.

(B) Provision of Discounted Prices at the Point-of-Sale.—Except as provided in paragraphs (c) and (d) of this subsection, discounted prices shall be provided to the applicable beneficiary at the pharmacy or by the mail order service at the point-of-sale of an applicable drug.

(C) Timing of Agreement.—

(i) Special Rule for 2010 and 2011.—In order for an agreement with a manufacturer to be in effect under this section with respect to the period beginning on July 1, 2010, and ending on December 31, 2011, the manufacturer shall enter into such agreement not later than May 1, 2010.

(ii) 2012 and Subsequent Years.—In order for an agreement with a manufacturer to be in effect under this section with respect to plan year 2012 or a subsequent plan year, the manufacturer shall enter into such agreement (or such agreement shall be renewed under paragraph (4)(A) not later than January 30 of the preceding year.

(2) Provision of Appropriate Data.—Each manufacturer with an agreement in effect under this section shall collect and have available appropriate data, as determined by the Secretary, to ensure that it can demonstrate to the Secretary the compliance with the requirements of this program.

(3) Compliance with Requirements for Administration of Program.—Each manufacturer with an agreement in effect under this section shall comply with requirements for appropriate enforcement under subsection (d)(3) within not less than 30 days prior to the effective date of such termination.

(c) Duties Described and Special Rule for Supplemental Benefits.—

(1) Duties Described.—The duties described in subsection (b) of this section are the following: (i), the establishment of procedures to provide such discounted prices as soon as practicable after the point-of-sale; (ii) the establishment of procedures to ensure that, not later than the applicable number of calendar days after the dispensing of an applicable drug by a pharmacy or mail order service, the pharmacy or mail order service is reimbursed for an amount equal to the difference between—

(I) the negotiated price of the applicable drug; and

(II) the discounted price of the applicable drug;

(v) the establishment of procedures to ensure that the discounted price for an applicable drug under this section is applied before any coverage or financial assistance under other health benefit plans or programs that provide coverage or financial assistance for the purchase or provision of prescription drug coverage on behalf of applicable beneficiaries as the Secretary may specify; and

(vi) the establishment of procedures to implement the special rule for supplemental benefits under paragraph (2); and

(vii) providing a reasonable dispute resolution mechanism to resolve disagreements between manufacturers, applicable beneficiaries, and the third party with a contract under subsection (d)(3).

(2) Monitoring Compliance.—

(i) In General.—The Secretary shall monitor compliance by a manufacturer with the terms of an agreement under this section.

(ii) Special Rule.—If the Secretary, in consultation with the Secretary of such noncompliance for appropriate enforcement under subsection (e).
(C) Collection of data from prescription drug plans and MA–PD plans.—The Secretary may collect appropriate data from prescription drug plans and MA–PD plans in a timeframe that allows for the examination of the rebates and discounts for applicable drugs under this section.

(2) Special rule for supplemental benefits. For plan year 2010 and each subsequent plan year, in the case where an applicable beneficiary has supplemental benefits with respect to applicable drugs under the prescription drug plan or MA–PD plan that the applicable beneficiary is enrolled in, the applicable beneficiary shall not be provided a discounted price for applicable drugs under this section until after such supplemental benefits have been applied with respect to the applicable drug.

(d) Administration.—

(1) In general.—Subject to paragraph (2), the Secretary shall provide for the implementation of this section, including the performance of the duties described in subsection (c)(1).

(2) Limitation.—

(A) In general.—Subject to subparagraph (B), in providing for such implementation, the Secretary shall not receive or distribute any funds of a manufacturer under the program.

(B) Exception.—The limitation under subparagraph (A) shall not apply to the Secretary with respect to drugs dispensed during the period beginning on July 1, 2010, and ending on December 31, 2010, but only if the Secretary determines that the exception to such limitation under this subparagraph is necessary in order for the Secretary to begin implementation of this section and provide applicable beneficiaries timely access to discounted prices during such period.

(3) Third parties.—The Secretary shall enter into a contract with 1 or more third parties to administer the requirements established by the Secretary in order to carry out this section. At a minimum, the contract with a third party under the preceding sentence shall require that the third party—

(A) receive and transmit information between the Secretary, manufacturers, and other individuals or entities the Secretary determines appropriate;

(B) receive, distribute, or facilitate the distribution of funds of manufacturers to appropriate individuals or entities in order to meet the obligations of manufacturers under agreements under this section;

(C) provide adequate and timely information to manufacturers, consistent with the agreement with the manufacturer under this section, as necessary for the manufacturer to fulfill its obligations under this section; and

(D) permit manufacturers to conduct periodic audits, directly or through contracts, of the data and information used by the third party to determine discounts for applicable drugs of the manufacturer under the program.

(4) Performance requirements.—The Secretary shall establish performance requirements for a third party with a contract under paragraph (3) and safeguards to protect the independence and integrity of the activities carried out by the third party under the program under this section.

(5) Authority to require contracts.—The Secretary may implement the program under this section by program instruction or otherwise.

(6) Administration.—Chapter 35 of title 44, United States Code, shall not apply to the program under this section.

(e) Enforcement.—

(1) Audits.—Each manufacturer with an agreement under this section shall be subject to periodic audit by the Secretary.

(2) Civil money penalty.—
(ii) by moving such subparagraph 2 ems to the left; and
(iii) by striking the period at the end and inserting ‘‘; and’’;
(D) adding at the end the following new subparagraph: ‘‘(J) a discount in the price of an applicable drug (as defined in paragraph (2) of section 1860D–14A) that is waived by the Secretary without regard to any reduction in such premium as a result of any beneficiary rebate under section 1854(b)(1)(C) or bonus payment under section 1853m shall remain available until January 1, 2012.’’ before the period at the end.
(3) EFFECTIVE DATE.—The amendments made by the subsection shall apply to drugs dispensed on or after July 1, 2010.
SEC. 3302. IMPROVEMENT IN DETERMINATION OF MEDICARE PART D LOW-INCOME BENCHMARK PREMIUMS.
(a) IN GENERAL.—Section 1860D–1(h)(2)(B)(iii) of the Social Security Act (42 U.S.C. 1395w–114(h)(2)(B)(iii)) is amended by inserting ‘‘, or any discounts provided by manufacturers under the Medicare coverage gap discount program under section 1860D–14A’’ before the period at the end.
(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to premiums for months beginning on or after January 1, 2011.
SEC. 3303. VOLUNTARY DE MINIMIS POLICY FOR SUBSIDY ELIGIBLE INDIVIDUALS WHOENROLL IN CERTAIN OUTREACH ACTIVITIES.
(a) IN GENERAL.—Section 1860D–14(a)(1)(A) of the Social Security Act (42 U.S.C. 1395w–114(a)(1)(A)) is amended by adding at the end the following new subparagraph:
‘‘(5) WAIVER OF DE MINIMIS PREMIUMS.—The Secretary shall, under procedures established by the Secretary, permit a prescription drug plan or a MA–PD plan to waive the monthly beneficiary premium for a subsidy eligible individual if the amount of such premium is de minimis. If such premium is waived under the plan, the Secretary shall not require the subsidy eligible individual enrolled in the plan to other plans based on the fact that the monthly beneficiary premium under the plan was greater than the low-income cash assistance amount.
(b) AUTHORIZING THE SECRETARY TO AUTO–ENROLL SUBSIDY ELIGIBLE INDIVIDUALS IN PLANS THAT WAVE DE MINIMIS PREMIUMS.—Section 1860D–1(h)(1) of the Social Security Act (42 U.S.C. 1395w–101(b)(1)) is amended—
(1) in subparagraph (C), by inserting ‘‘except as provided in subparagraph (D),’’ after ‘‘shall,’’
(2) by adding at the end the following new subparagraph:
‘‘(D) SPECIAL RULE FOR PLANS THAT WAIVE DE MINIMIS PREMIUMS.—The process established under subparagraph (A) may include, in the case of a plan that waives the monthly beneficiary premium for a subsidy eligible individual (as defined in section 1860D–1(a)(3)) who has failed to enroll in a prescription drug plan or an MA–PD plan, for the enrollment in a prescription drug plan or an MA–PD plan that has waived the monthly beneficiary premium for such subsidy eligible individual under section 1860D–14A, if such plan waives the monthly beneficiary premium for any beneficiary rebate under section 1854(b)(1)(C) or bonus payment under section 1853m shall remain available until the beginning of the first month following the 30th day of such reassignment, with—
(1) information on formulary differences between the individual’s former plan and the plan to which the individual is reassigned with respect to the individual’s drug regimen;
(2) a description of the individual’s right to request a coverage determination, exception, or reconsideration under section 1860D–4(g), bring an appeal under section 1860D–4(b), or resolve a grievance under section 1860D–4(c).
SEC. 3306. FUNDING OUTREACH AND ASSISTANCE FOR LOW-INCOME PROGRAMS.
(a) ADDITIONAL FUNDING FOR STATE HEALTH INSURANCE RURAL PROGRAMs.—Subsection (a)(1)(B) of section 119 of the Medicare Improvements for Patients and Providers Act of 2008 (42 U.S.C. 1395w–23(f)) is amended by striking ‘‘(42 U.S.C. 1395w–23(f))’’ and all that follows through the period at the end and inserting ‘‘(42 U.S.C. 1395w–23(f)), to the Centers for Medicare & Medicaid Services Program Management Account’’.
(b) ADDITIONAL FUNDING FOR AREA AGN’’S ON AGING.—Subsection (b)(1)(B) of such section 119 is amended by striking ‘‘(42 U.S.C. 1395w–23(f))’’ and all that follows through the period at the end and inserting ‘‘(42 U.S.C. 1395w–23(f)), to the Administration on Aging’’.
(1) for fiscal year 2009, of $7,500,000; and
(2) for the period of fiscal years 2010 through 2012, of $15,000,000.
Amounts appropriated under this subparagraph remain available until expended.
(c) ADDITIONAL FUNDING FOR AGING AND DISABILITY RESOURCE CENTERS.—Subsection (c)(1)(B) of such section 119 is amended by striking ‘‘(42 U.S.C. 1395w–23(f))’’ and all that follows through the period at the end and inserting ‘‘(42 U.S.C. 1395w–23(f)), to the Administration on Aging’’.
(1) for fiscal year 2009, of $5,000,000; and
(2) for the period of fiscal years 2010 through 2012, of $10,000,000.
Amounts appropriated under this subparagraph remain available until expended.
(i) for the period of fiscal years 2010 through 2012, of $5,000,000.
(ii) for the period of fiscal years 2010 through 2012, of $5,000,000.
SEC. 3307. IMPROVING FORMULARY REQUIREMENTS AND PLANS AND MA–PD PLANS WITH RESPECT TO CERTAIN CATEGORIES OR CLASSES OF DRUGS.
(a) IMPROVING FORMULARY REQUIREMENTS.—Section 1860D–4(b)(3)(G) of the Social Security Act is amended to read as follows:
‘‘(G) REQUIRED INCLUSION OF DRUGS IN CERTAIN CATEGORIES AND CLASSES.—
(1) FORMULARY REQUIREMENTS.—In general.—Subclause (II) of section 119 is amended by adding at the end the following new subclause:
‘‘(II) IDENTIFICATION OF DRUGS IN CERTAIN CATEGORIES AND CLASSES.—
(1) IN GENERAL.—Subject to clause (iv), the Secretary shall identify, as appropriate, categories and classes of drugs for which the Secretary determines are of clinical concern.
(2) CRITERIA.—The Secretary shall establish criteria established by the Secretary in making determinations under clause (I) (or to otherwise limit access to such a drug, including through prior authorization or utilization management).
(3) REQUIREMENT FOR CERTIFICATION.—Until such time as the Secretary establishes the criteria under clause (I)(II) the
following categories and classes of drugs shall be identified under clause (ii) (i) (1):

"(i) Anticonvulsants.
"(ii) Antidepressants.
"(iii) Antipsychotics.
"(iv) Antiretrovirals.
"(v) Immunossuppressants for the treatment of autoimmune diseases.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to plan year 2011 and subsequent plan years.

SEC. 3308. REDUCING PART D PREMIUM SUBSIDY FOR HIGH-INCOME BENEFICIARIES.

(a) INCOME-RELATED INCREASE IN PART D PREMIUM

(1) IN GENERAL.—Section 1860D–13(a) of the Social Security Act (42 U.S.C. 1395w–113(a)) is amended by adding at the end the following new paragraph:

"(7) INCREASE IN BASE BENEFICIARY PREMIUM BASED ON INCOME.—

"(A) IN GENERAL.—In the case of an individual whose modified adjusted gross income exceeds the threshold amount applicable under paragraph (2) of section 1839(i) (including application of paragraph (5) of such section) for the calendar year, the monthly amount of the beneficiary premium applicable under this section for a month after December of the taxable year applicable under this paragraph (B) shall be increased by the monthly adjustment amount specified in subparagraph (B).

"(B) MONTHLY ADJUSTMENT AMOUNT.—The monthly amount of the beneficiary premium specified in this subparagraph for an individual for a month is determined for the meaning given such term in subparagraph (A) of section 1839(i)(4), determined for the purpose of determining the monthly adjustment amount under subparagraph (A) of such section.

"(i) the quotient obtained by dividing—

"(I) the modified adjusted gross income (as computed under paragraph (2)) by

"(II) 25.5 percent; and

"(ii) the base beneficiary premium (as computed under paragraph (2)).

"(C) MODIFIED ADJUSTED GROSS INCOME.—

For purposes of this paragraph, the term 'modified adjusted gross income' has the meaning given such term in subparagraph (A) of section 1839(i)(4), determined for the taxable year applicable under subparagraphs (B) and (C) of such section.

"(D) DETERMINATION BY COMMISSIONER OF SOCIAL SECURITY.—The Commissioner of Social Security shall make any determination necessary to carry out the income-related increase in the base beneficiary premium under this paragraph.

"(E) PROCEDURES TO ASSURE CORRECT INCOME-RELATED INCREASE IN BASE BENEFICIARY PREMIUM SUBSIDY AMOUNT.

"(i) DISCLOSURE OF BASE BENEFICIARY PREMIUM.—Not later than September 15 of each year beginning with 2010, the Secretary shall disclose to the Commissioner of Social Security the amount of the base beneficiary premium (as computed under paragraph (2)) for the purpose of carrying out the income-related increase in the base beneficiary premium under this paragraph with respect to the following year.

"(ii) ADDITIONAL DISCLOSURE.—Not later than August 31 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 increased premium for the base beneficiary premium under this paragraph with respect to the following year:

"(I) the modified adjusted gross income threshold amounts specified 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)(1) (including application of paragraph (5) of such section).

"(III) the monthly adjustment amount specified in subparagraph (B).

"(IV) any other information the Commissioner of Social Security determines necessary to carry out the income-related increase in the base beneficiary premium under this paragraph.

"(F) RULE OF CONSTRUCTION.—The formula used to determine the monthly adjustment amount specified under subparagraph (B) shall only be used for the purpose of determining such monthly adjustment amount under subparagraph (A).

(2) COLLECTION OF MONTHLY ADJUSTMENT AMOUNT.—Section 1860D–13(c) of the Social Security Act (42 U.S.C. 1395w–113(c)) is amended—

"(A) in paragraph (1), by striking "(2) and (3)" and inserting "(2), (3), and (4)"; and

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

"(4) COLLECTION OF MONTHLY ADJUSTMENT AMOUNT.—

"(A) IN GENERAL.—Notwithstanding any provision of this subsection or section 1854(d)(2), subject to subparagraph (B), the amount of the income-related increase in the base beneficiary premium for an individual for a month (as determined under subsection (a)(7)) shall be paid through withholding from benefit payments in the manner provided under section 1902(q)(1)(B).

"(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 such subparagraph on a withholding basis under such paragraph.

"(C) TREATMENT OF DETERMINATION.—

"(i) DISCLOSURE TO OTHER AGENCIES.—

"(II) the base beneficiary premium (as computed under paragraph (2)),

"(3) INTERNAL REVENUE CODE.—Section 1860D–13(a)(1) of the Social Security Act (42 U.S.C. 1395w–113(a)(1)) is amended—

"(A) by redesignating subparagraph (F) as subparagraph (G);

"(B) in subparagraph (G), as redesignated by subparagraph (A), by striking "(D) and (E)" and inserting "(D), (E), and (F)"; and

"(C) by inserting after subparagraph (G) the following new subparagraph:

"(F) INCREASE BASED ON INCOME.—The monthly beneficiary premium shall be increased pursuant to paragraph (7).

"(2) INTERNAL REVENUE CODE.—Section 6103(l)(20) of the Internal Revenue Code of 1986 (relating to disclosure of return information to the Social Security Administration) is amended by striking clause (i) and inserting "(i) the base beneficiary premium, the monthly adjustment amount, or the increased premium amount with respect to a taxpayer described in subparagraph (A) to officers, employees, and contractors of the Department of Justice for use in judicial proceedings to the extent that such disclosure is necessary for the collection of the premium subsidy amount or the increased premium amount.

"(III) return information with respect to a taxpayer described in subparagraph (A) to officers, employees, and contractors of the Department of Health and Human Services to the extent necessary to resolve administrative appeals on the premium subsidy adjustment or increased premium, and

"(IV) return information with respect to a taxpayer described in subparagraph (A) to officers, employees, and contractors of the Department of Justice for use in judicial proceedings to the extent necessary to carry out the purposes described in clause (i)."

SEC. 3309. ELIMINATION OF COST SHARING FOR CERTAIN DUAL ELIGIBLE INDIVIDUALS.

Section 1860D–14(a)(1)(D)(i) of the Social Security Act (42 U.S.C. 1395w–114(a)(1)(D)(i)) is amended by inserting in subsection (a) the words "cheaper alternative for" after "cheaper alternative, if any, in the form of covered prescription drug coverage under a Medicare Part D plan (other than

"(a) IN GENERAL.—Section 1860D–4(c) of the Social Security Act (42 U.S.C. 1395w–104(c)) is amended by adding at the end the following new paragraph:

"(5) REDUCING WASTEFUL DISPENSING OF OUTPATIENT PRESCRIPTION DRUGS IN LONG-TERM CARE FACILITIES.

"(a) IN GENERAL.—

"(B) AGREEMENTS.—In the case where the Secretary determines that a Medicaid managed care organization, Medicare– Prescription Drug Plan or MA–PD plan to utilize specific, uniform dispensing techniques, as determined by the Secretary, plans the Secretary may disclose—

"(i) by striking "Return information" and inserting "Return information to other stakeholders the Secretary determines, in consultation with relevant stakeholders (including representatives of nursing facilities, residents of nursing facilities, pharmacists, the pharmacy industry (including retail and long-term care pharmacy), prescription drug plans, MA–PD plans, and any other stakeholders the Secretary determines appropriate), such as by specified automated dose dispensing, when dispensing covered part D drugs to enrollees who reside in a long-term care facility in order to reduce waste and associated with the following

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to plan years beginning on or after January 1, 2012.
SEC. 3311. IMPROVED MEDICARE PRESCRIPTION DRUG PLAN AND MA–PD PLAN COMPLAINT SYSTEM.

(a) In general.—The Secretary shall develop and maintain a complaint system, that is widely known and easy to use, to collect and maintain information on MA–PD plan and Part D plan complaints that are received (including by telephone, letter, e-mail, or any other means) by the Secretary (including by a regional office of the Department of Health and Human Services, the Medicare Beneficiary Ombudsman, a subcontractor, a carrier, a fiscal intermediary, and a Medicare administrative contractor under section 1862 of the Social Security Act (42 U.S.C. 1395k(k))) through the date on which the complaint is resolved. The system shall be able to report and initiate appropriate interventions and monitoring based on substantial complaints and to guide quality improvement.

(b) Model electronic complaint form.—The Secretary shall develop a model electronic complaint form to be used for reporting plan complaints under the system. Such form shall be prominently displayed on the plan website and on the Medicare Beneficiary Ombudsman website.

(c) By the Secretary.—The Secretary shall submit to Congress annual reports on the system. Such reports shall include an analysis of the number and types of complaints reported in the system, geographic variations in such complaints, the timeliness of agency or plan responses to such complaints, and the resolution of such complaints.

(d) Definitions.—In this section:

(1) MA–PD PLAN.—The term ‘‘MA–PD plan’’ has the meaning given such term in section 1860D–21(a)(8) of such Act (42 U.S.C. 1395w–151(a)(8)).

(2) PRESCRIPTION DRUG PLAN.—The term ‘‘prescription drug plan’’ has the meaning given such term in section 1860D–4(a)(14) of such Act (42 U.S.C. 1395w–151(a)(14)).

(3) SECRETARY.—The term ‘‘Secretary’’ means the Secretary of Health and Human Services.

(4) SYSTEM.—The term ‘‘system’’ means the plan complaint system developed and maintained under subsection (a).

SEC. 3312. UNIFORM EXCEPTIONS AND APPEALS PROCESS FOR PRESCRIPTION DRUG PLANS AND MA–PD PLANS.

(a) In general.—Section 1860D–4(b)(3) of the Social Security Act (42 U.S.C. 1395w–102(b)(3)) is amended by adding at the end the following new subparagraph:

‘‘(ii) provide instant access to such process by enrollees through a toll-free telephone number and an Internet website.’’.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to exceptions and appeals appeals (including, to the extent the Secretary determines feasible, a single, uniform model form for use under such process) with respect to the determination of prescription drug coverage for an enrollee under the plan; and

‘‘(ii) provide instant access to such process by enrollees through a toll-free telephone number and an Internet website.’’.

SEC. 3313. OFFICE OF THE INSPECTOR GENERAL STUDIES AND REPORTS.

(a) STUDY AND ANNUAL REPORT ON PART D FORMULARIES COMMONLY USED BY DUAL ELIGIBLES.—

(1) STUDY.—The Inspector General of the Department of Health and Human Services shall conduct a study of the extent to which prescription drug plans and MA–PD plans under part D include drugs commonly used by full-benefit dual eligible individuals (as defined in section 1927(c)(6) of the Social Security Act (42 U.S.C. 1395w–21(c)(6))).

(2) ANNUAL REPORT.—Not later than July 1 of each year (beginning with 2011), the Inspector General shall submit to Congress a report on the study conducted under paragraph (1), including any recommendations as the Inspector General determines appropriate.

(b) STUDY AND REPORT ON PRESCRIPTION DRUG PRICES UNDER MEDICARE PART D AND MEDICARE.—

(1) STUDY.—

(A) IN GENERAL.—The Inspector General of the Department of Health and Human Services shall conduct a study on prices for covered part D drugs under the Medicare prescription drug program under part D of title XVIII of the Social Security Act and for covered outpatient drugs under title XIX. Such study shall include the following:

(i) A comparison, with respect to the 200 most frequently dispensed covered part D drugs under such program and covered outpatient drugs under such title, of the prices paid for covered part D drugs by PDP sponsors of prescription drug plans and Medicare Advantage organizations offering MA–PD plans; and

(ii) An assessment of—

(I) the financial impact of any discrepancies in such prices on the Federal Government; and

(II) the financial impact of any such discrepancies on enrollees under part D or individuals eligible for medical assistance under a State plan.

(B) PRICE.—For purposes of subparagraph (A), the price of a covered part D drug or a covered outpatient drug shall include any rebate or discount under such program or such title, respectively, including any negotiated price concession described in section 1860D–2(b)(1)(B) of the Social Security Act (42 U.S.C. 1395w–102(b)(1)(B)) or rebate under an agreement under section 1827 of the Social Security Act (42 U.S.C. 1395w–27).

(C) AUTHORITY TO COLLECT ANY NECESSARY INFORMATION.—Notwithstanding any other provision of law, the Inspector General of the Department of Health and Human Services shall be able to obtain any information related to the prices of covered part D drugs under such program and covered outpatient drugs under such title necessary to carry out the comparison under subparagraph (A).

(2) REPORT.—

(A) IN GENERAL.—Not later than October 1, 2011, subject to subparagraph (B), the Inspector General shall submit to Congress a report containing the results of the study conducted under paragraph (1), together with such recommendations for such legislation and administrative action as the Inspector General determines appropriate.

(B) LIMITATION ON INFORMATION CONTAINED IN REPORT.—The report submitted under subparagraph (A) shall not include any information that the Inspector General determines is proprietary or is likely to be negatively impacted by the ability of a PDP sponsor or a State plan under title XIX to negotiate prices for covered part D drugs or covered outpatient drugs, respectively.

(c) MEANING OF ‘‘COVERED PART D DRUG’’ AND ‘‘COVERED OUTPATIENT DRUG’’.—

(1) COVERED PART D DRUG.—The term ‘‘covered part D drug’’ has the meaning given such term in section 1927(c)(6) of the Social Security Act (42 U.S.C. 1395w–21(c)(6)).

(2) COVERED OUTPATIENT DRUG.—The term ‘‘covered outpatient drug’’ has the meaning given such term in section 1927(k) of such Act (42 U.S.C. 1395w–27(k)).
process, to fully reimburse PDP sponsors with respect to prescription drug plans and MA organizations with respect to MA–PD plans for the reduction in beneficiary cost sharing associated with the application of subparagraph (A):

“(ii) the Secretary shall develop an estimate of the additional increased costs attributable for increased drug utilization and financing and administrative costs and shall use such estimate to adjust payments to PDP spon-
sors with respect to prescription drug plans under this part and MA organizations with respect to MA–PD plans under part C; and

“(vii) the Secretary shall establish procedures for the reimbursement of part D eligible individuals who are covered under such a plan for costs which are incurred before the date of initial implementation of subparagraph (A) and which would be reimbursed under such a plan if such implementa-
tion occurred as of January 1, 2010.

“(C) NO EFFECT ON SUBSEQUENT YEARS.—The increase under subparagraph (A) shall only apply with respect to the plan year begin-
ing on January 1, 2010, and the initial coverage limit for plan years beginning on or after January 1, 2010, shall be determined as if subparagraph (A) had never applied.

Subtitle E—Ensuring Medicare Sustainability

SEC. 3401. REVISION OF CERTAIN MARKET BASKET UPDATES AND INCORPORATION OF BUDGETARY IMPROVEMENTS INTO MARKET BASKET UPDATES THAT DO NOT ALREADY INCORPORATE SUCH IMPROVEMENTS.

(a) INPATIENT ACUTE HOSPITALS.—Section 1886(b)(3)(B) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)), as amended by section 3001 of title III of the Patient Protection and Affordable Care Act that, if determined in the affirmative, would clear such Act for enroll-
ment; over

(i) the excess (if any) of—

“(aa) the total percentage of the non-elderly insured population for such preceding fiscal year (as estimated by the Secretary); exceeds

(vii) 5 percentage points.”.

(b) SKILLED NURSING FACILITIES.—Section 1886(b)(3)(B) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)) is amended by adding at the end the following new paragraphs:

“(1) by striking “per-
centage point,” if for such fiscal year—

“(i) in GENERAL.—Subject to clause (ii), the term”; and

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

“(ii) ADJUSTMENT.—For fiscal year 2012 and each subsequent fiscal year, any annual update to a standard Federal rate for discharges for the hospital during the rate year, shall be reduced—

“(i) for rate year 2012 and each subsequent rate year, by the productivity adjustment described in subclause (II); and

(3) in the first sentence of clause (vii), by inserting “(determined without regard to clause (ix), (x), (xi), or (xii))” after “one-quarter”;

(iii) in clause (ii), by inserting “(determined without regard to clause (vii), (ix), or (xii))” after “(ii)” the second time it appears; and

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

“(xii) For 2012 and each subsequent fiscal year, after determining the applicable percentage increase described in clause (i) being less than 0.0 for a fiscal year, and may result in payment rates for the preceding fiscal year.

(xiii) Clause (xii) shall be applied with respect to any of fiscal years 2012 through 2019 by substituting ‘0.0 percentage point’ for ‘0.2 percentage point’ if, for such rate year—

(i) the excess (if any) of—

“(aa) the total percentage of the non-elderly insured population for the preceding fiscal year (based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Patient Protection and Affordable Care Act that, if determined in the affirmative, would clear such Act for enroll-
ment); over

(ii) the total percentage of the non-elderly insured population for such preceding year (as estimated by the Secretary); exceeds

(iii) 5 percentage points.”.

(d) INPATIENT REHABILITATION FACILITIES.—Section 1886(e)(9)(B) of the Social Security Act (42 U.S.C. 1395w(d)(3)(B)) is amended—

(1) in subparagraph (C)—

(A) by striking “FACTOR.—For purposes” after “(i) in GENERAL.—For purposes”;

(B) by inserting “subject to clause (ii)” before the period at the end of the first sen-
tence of clause (i), as added by paragraph (1); and

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

“(ii) ADJUSTMENT.—For purposes of paragraph (C)(ii), the other adjustment described in this subparagraph is—

(i) for each of fiscal years 2010 through 2019, 0.2 percentage points.

(ii) subject to clause (ii), for each of fiscal years 2010 through 2019, 0.2 percentage point.

(iii) the excess (if any) of—

“(aa) the total percentage of the non-elderly insured population for the preceding fiscal year (based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Patient Protection and Affordable Care Act that, if determined in the affirmative, would clear such Act for enroll-
ment); over

“(bb) the total percentage of the non-elderly insured population for such preceding fiscal year (as estimated by the Secretary); exceeds

(v) 5 percentage points.”.

(e) HOME HEALTH AGENCIES.—Section 1861(s)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(s)(5)(B)) is amended—

(1) in clause (ii)(V), by striking “(as projected by the Secretary for the 10-year annual period, is a productivity adjustment term”;

and

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

“(vi) ADJUSTMENTS.—After determining the home health market basket percentage

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increase under clause (iii), and after application of clause (v), the Secretary shall reduce such percentage—"(i) for 2015 and each subsequent year, by the productivity adjustment described in section 1886(b)(3)(B)(x)(I); and
"(ii) for each of 2011 and 2012, by 1 percentage point.

The application of this clause may result in the home health market basket percentage increase under clause (iii) being less than 0.0 for a year, and may result in payment rates under the system described in this subsection for a year being less than such payment rates for the preceding year.

(2) HOSPITALS.—Section 1886 of the Social Security Act, as amended by sections 3001, 3008, 3025, and 3133, is amended by adding at the end the following new subsection:
"(e) PROSPECTIVE PAYMENT FOR PSYCHIATRIC HOSPITALS.—
"(1) REFERENCE TO ESTABLISHMENT AND IMPLEMENTATION OF SYSTEM.—For provisions related to the establishment and implementation of a prospective payment system for payments under this title for inpatient hospital services furnished by psychiatric hospitals (as described in clause (i) of subsection (d)(1)(B) and psychiatric units (as described in the preceding clause of such subsection), see section 124 of the Medicare, Medicaid, and SCHIP Balanced Budget Reconciliation Act of 1999.

"(2) IMPLEMENTATION FOR RATE YEAR BEGINNING IN 2010 AND SUBSEQUENT RATE YEARS.—

"(A) IN GENERAL.—In implementing the system described in paragraph (1) for the rate year beginning in 2010 and any subsequent rate year, any update to a base rate for days during the rate year for a psychiatric hospital or unit, respectively, shall remain.

"(B) FOR FUNDS FOR YEARS 2011 THROUGH 2019.—For funds for years 2011 through 2019, the Secretary shall determine the productivity adjustment for such year by the formula described in section 1886(b)(3)(B)(x)(I) and (II), and may result in payment rates under the system described in this subsection for a year being less than such payment rates for the preceding year.

"(3) OTHER ADJUSTMENT.—

"(A) IN GENERAL.—For purposes of paragraph (2)(A)(ii), the other adjustment described in this paragraph is—

"(i) for each of the rate years beginning in 2010 and 2011, 0.5 percentage point; and
"(ii) subject to subparagraph (B), for each of the rate years beginning in 2012 through 2019, 0.2 percentage point.

"(B) SPECIAL RULE.—Subparagraph (A)(ii) shall be applied with respect to any of rate years 2014 through 2019 by substituting ‘0.6 percentage points’ for ‘0.2 percentage points’.

The application of this paragraph may result in such update being less than 0.0 for a rate year, and may result in payment rates under the system described in this subsection for a rate year being less than such payment rates for the preceding rate year.

"(4) OTHER ADJUSTMENT.—

"(A) IN GENERAL.—For purposes of paragraph (2)(A)(ii), the other adjustment described in this paragraph is—

"(i) for each of 2010 and 2011, 0.25 percentage point; and

"(ii) for each of 2012 through 2019, 0.2 percentage point.

The application of this paragraph may result in such update being less than 0.0 for a rate year, and may result in payment rates under the system described in this subsection for a rate year being less than such payment rates for the preceding year.

"(G) OTHER ADJUSTMENT.—

"(1) ADJUSTMENT.—For purposes of subparagraph (F)(ii), the adjustment described in this subparagraph is—

"(i) for each of 2010 and 2011, 0.25 percentage point; and

"(ii) subject to clause (i), for each of 2012 through 2019, 0.2 percentage point.

(2) REDUCTION OF OTHER ADJUSTMENT.—

"(I) for each of 2010 and 2011, 0.25 percentage point.

The application of this subparagraph may result in the percentage increase under subparagraph (B) being less than 0.0 for a year, and may result in payment rates under the system described in this subsection for a year being less than such payment rates for the preceding year.

(3) AMBULATORY SURGICAL CENTER SERVICES.—Section 1833(i)(2)(D) of the Social Security Act (42 U.S.C. 1395m(i)(3)) is amended—

"(i) by redesigning clause (v) as clause (vi); and

"(ii) by inserting after clause (iv) the following new clause:

"(l) LABORATORY SERVICES.—Section 1833(h)(2)(A) of the Social Security Act (42 U.S.C. 1395l(h)(2)(A)) is amended—

"(i) by redesigning clause (v) as clause (vi); and

"(ii) by inserting after clause (iv) the following new clause:

"(g) PRO hassocial security act (42 u.s.c. 1395f(t)(1)(c)) as amended by section 3133, is

amended by adding at the end the following new clauses:

"(iv) After determining the market basket percentage increase under clause (ii)(VII) or (iii), the Secretary shall reduce such percentage—

"(I) for 2012 and each subsequent fiscal year, by the productivity adjustment described in section 1886(b)(3)(B)(x)(I); and

"(ii) for each of 2010 through 2019, by 0.5 percentage point.

The application of this clause may result in the market basket percentage increase under clause (ii)(VII) or (iii), as applicable, being less than 0.0 for a year, and may result in payment rates under this subsection for a fiscal year being less than such payment rates for the preceding fiscal year.

"(v) Clause (iv)(IV) shall be applied with respect to any of fiscal years 2014 through 2019 by substituting ‘0.0 percentage points’ for ‘0.5 percentage point’, if for such fiscal year—

"(I) the excess (if any) of—

"(aa) the total percentage of the non-elderly insured population for the preceding year (based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Patient Protection and Affordable Care Act that, if determined in the affirmative, would clear such Act for enrollment); over

"(bb) the total percentage of the non-elderly insured population for such preceding fiscal year (as estimated by the Secretary); exceeds

"(II) 5 percentage points.

"(h) DIALYSIS.—Section 1881(b)(14)(F) of the Social Security Act (42 U.S.C. 1395y(b)(14)(F)) is amended—

"(i) in clause (i), by striking ‘‘subject to clause (v)’’; and

"(ii) in subparagraph (B), by striking clause (v) and inserting ‘‘subject to clause (v)’’.

The application of this subparagraph may result in such update being less than 0.0 for a rate year, and may result in payment rates under the system described in this subsection for a year being less than such payment rates for the preceding year.

The application of this paragraph may result in such update being less than 0.0 for a year, and may result in payment rates under the system described in this subsection for a year being less than such payment rates for the preceding year.

"(i) ADJUSTMENT.—For purposes of subparagraph (C)(iv), the adjustment described in section 1886(b)(3)(B)(x)(I); and

"(ii) by adding at the end the following new flush sentence:

"The application of the paragraph may result in the percentage increase under subparagraph (B) being less than 0.0 for a year, and may result in payment rates under the system described in this subsection for a year being less than such payment rates for the preceding year.

(2) LABORATORY SERVICES.—Section 1833(h)(2)(D) of the Social Security Act (42 U.S.C. 1395l(h)(2)(D)) is amended—

"(i) by redesigning clause (v) as clause (vi); and

"(ii) by inserting after clause (iv) the following new clause:

"(l) LABORATORY SERVICES.—Section 1833(h)(2)(A) of the Social Security Act (42 U.S.C. 1395l(h)(2)(A)) is amended—"
(B) by striking "through 2013" and inserting "and 2010"; and
(2) by adding at the end the following new clause:
"(iv) After determining the adjustment to the fee schedules under clause (1), the Secretary shall reduce such adjustment—
"(I) for 2011 and each subsequent year, by the productivity adjustment described in section 1886(b)(3)(B)(ix)(II); and
"(II) for each of 2011 through 2015, by 1.75 percentage points.
Subclause (I) shall not apply in a year where the adjustment to the fee schedules determined under clause (1) is 0.0 or a percentage decrease for a year. The application of the productivity adjustment under subclause (I) shall be an adjustment to the fee schedules under clause (1) being less than 0.0 for a year. The application of subclause (II) may result in an adjustment to the fee schedules under clause (1) being less than 0.0 for a year, and may result in payment rates for a year being less than such payment rates for the preceding year.

(m) CERTAIN DURABLE MEDICAL EQUIPMENT.—Section 1395m(a)(14) of the Social Security Act (42 U.S.C. 1395m(a)(14)) is amended—
(1) by striking "(A) Subject to" and inserting "(A) Subject to;"
(2) by striking the second sentence and inserting the following new subparagraph:
"(B) Any fee schedule established under this paragraph for such item or service shall be updated—
"(i) for years before 2011—
"(I) subject to subclause (I), by the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the preceding year; and
"(II) for years before 2011—
"(I) the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year, reduced by—
"(II) the productivity adjustment described in section 1886(b)(3)(B)(ix)(II); and
"(3) by adding at the end the following flush sentence:
"The application of subparagraph (A)(ix)(II) may result in the covered item update under this paragraph being less than 0.0 for a year, and may result in payment rates under this subsection for a year being less than such payment rates for the preceding year.

(n) PROSTHETIC DEVICES, ORTHOTICS, AND PROSTHETIC ORTHOTIC SUPPLIES.—(1) the productivity adjustment described in section 1886(b)(3)(B)(ix)(II); and
(3) by adding at the end the following new clause:
"(x) for 2011 and each subsequent year—
"(I) the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year, reduced by—
"(II) the productivity adjustment described in section 1886(b)(3)(B)(ix)(II); and
(4) by adding at the end the following flush sentence:
"The application of subparagraph (A)(ix)(II) may result in the applicable percentage increase in the fee schedule for such item or service for 2011 being less than 0.0 for a year, and may result in payment rates under this subsection for a year being less than such payment rates for the preceding year.

(o) OTHER ITEMS.—Section 1821(e)(1) of the Social Security Act (42 U.S.C. 1396u(e)(1)) is amended—
(1) in the first sentence, by striking "Subject to" and inserting "(A) Subject to;"
(2) by striking the second sentence and inserting the following new subparagraph:
"(B) Any fee schedule established under this paragraph for such item or service shall be updated—
"(i) for years before 2011—
"(I) subject to subclause (II), by the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the preceding year; and
"(II) for years before 2011—
"(I) the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year, reduced by—
"(II) the productivity adjustment described in section 1886(b)(3)(B)(ix)(II); and
"(3) by adding at the end the following flush sentence:
"The application of subparagraph (B)(ix)(II) may result in the applicable percentage increase in the fee schedule for such item or service for 2011 being less than 0.0 for a year, and may result in payment rates under this subsection for a year being less than such payment rates for the preceding year.

(p) NO APPLICATION PRIOR TO APRIL 1, 2010.—Notwithstanding the preceding provisions of this section, the amendments made by subsections (a), (c), and (d) shall not apply to discharges occurring before April 1, 2010.

SEC. 3402. TEMPORARY ADJUSTMENT TO THE CALCULATION OF PART B PREMIUMS.

Section 1395m(h)(4) of the Social Security Act (42 U.S.C. 1395m(h)(4)) is amended—
(1) in paragraph (1), by striking "determined under clause (i) is 0.0 or a percentage points."; and
(2) by striking the second sentence and inserting "such amount for 2010; and

SEC. 3403. INDEPENDENT MEDICARE ADVISORY BOARD.

(a) BOARD.—
"(1) IN GENERAL.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), as amended by section 3022, is amended by adding at the end the following new section:
"INDEPENDENT MEDICARE ADVISORY BOARD.

SEC. 3404. TEMPORARY ADJUSTMENT TO INCOME THRESHOLDS.

(1) TEMPORARY ADJUSTMENT TO INCOME THRESHOLDS.—Notwithstanding any provision of this subsection during the period beginning on January 1, 2011, and ending on December 31, 2010—
"(A) the threshold amount otherwise applicable under paragraph (1) shall be equal to such amount for 2010; and
"(B) the dollar amounts otherwise applicable under paragraph (3)(C)(i) shall be equal to such dollar amounts for 2010.

SEC. 3405. INDEPENDENT MEDICARE ADVISORY BOARD.

(a) BOARD.—
"(1) IN GENERAL.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), as amended by section 3022, is amended by adding at the end the following new section:
"THE INDEPENDENT MEDICARE ADVISORY BOARD.

SEC. 3406. TEMPORARY ADJUSTMENT TO THE DETERMINATION OF PART B PREMIUMS.

Section 1395m(a)(14) of the Social Security Act (42 U.S.C. 1395m(a)(14)) is amended—
(1) by requiring the Chief Actuary of the Centers for Medicare & Medicaid Services to—
"(i) if the Board submits a proposal for such year. Such a report may, for years prior to 2020, include recommendations regarding improvement of systems for providers of services and suppliers who are not otherwise subject to the scope of the Board's recommendation for a proposal under this section. Any advisory report submitted under this subparagraph shall not be subject to the rules for congressional consideration under subsection (d).
"(2) PROPOSALS.—
"(A) REQUIREMENTS.—Each proposal submitted under this section in a proposal year shall meet each of the following requirements:
"(i) If the Chief Actuary of the Centers for Medicare & Medicaid Services has made a determination under paragraph (7)(A) in the determination year, the proposal shall include recommendations so that the proposal as a whole (after taking into account recommendations under clause (v)) will result in a net reduction in total Medicare program spending in the implementation year that is at least equal to the applicable savings target established under paragraph (7)(B) for such implementation year. In determining whether a proposal meets the requirements of this subsection, the Board shall assume that Medicare program spending during the 3-month period immediately preceding the implementation year shall be counted to the extent that such reductions are a result of the implementation of recommendations contained in the proposal for a change in the payment rate for an item or service that was effective during such period pursuant to subsection (e)(2)(A).
"(ii) The proposal shall not include any recommendation to ration health care, raise revenues or Medicare beneficiary premiums under section 1819, 1818A, or 1839, increase Medicare beneficiary cost-sharing (including deductibles, coinsurance, and copayments), or provide for the direct restriction of benefits or modify eligibility criteria.
"(iii) In the case of proposals submitted prior to December 31, 2018, the proposal shall not include any recommendation that would reduce payment rates for items and services furnished, prior to December 31, 2018, by providers of services (as defined in section 1861(d)(17)(C)) or suppliers (as defined in section 1861(d)) scheduled, pursuant to the amendments made by section 3401 of the Patient Protection and Affordable Care Act, to reduce payment rates that were effective during such period pursuant to subsection (e)(2)(A).
"(iv) As appropriate, the proposal shall include recommendations to reduce Medicare beneficiary cost-sharing (including deductibles, coinsurance, and copayments), or provide for the direct restriction of benefits or modify eligibility criteria.
payments under parts C and D, such as re-
ductions in direct subsidy payments to Medi-
care Advantage and prescription drug plans
specified under paragraph (1) and (2) of sec-
tion 1860D–15(a) that are related to ad-
ministrative expenses (including profits) for basic
coverage, denying high bids or removing
high bids for prescription drug coverage from
the competitive bidding program under section
1806D–13(a); and
(b) a copy of such proposal to the Medi-
care Payment Advisory Commission for its
review.

(6) PER CAPITA GROWTH RATE PROJECTIONS
BY CATEGORY.—
(A) IN GENERAL.—Subject to subsection
(3)(A), not later than April 30, 2013, and an-
nually thereafter, the Chief Actuary of the
Centers for Medicare & Medicaid Services shall
determine in each such year whether—
(i) the projected Medicare per capita
growth rate for the implementation year (as
defined under subparagraph (B)) exceeds
(ii) the projected Medicare per capita target
growth rate for the implementation year
as determined under paragraph (6)(A).

(B) MEDICARE PER CAPITA GROWTH RATE.—
(I) IN GENERAL.—For purposes of this sec-
tion, the Medicare per capita growth rate for
implementation year shall be calculated as
the projected 5-year average (ending with
such year) of the growth in Medicare pro-
care spending per unduplicated enrollee.

(ii) REQUIREMENT.—The projection under
clause (i) shall—
(I) to the extent that there is projected to
be a negative update to the single conversion
factor applicable to physicians’ services under
section 1806D–15(a), be increased by the negative
percentage that would otherwise apply; and
(II) take into account any delivery sys-
tem reforms or other payment changes that
have not been implemented by CMS or
other applicable rules but not yet implemented
as of the making of such calculation.

(C) MEDICARE PER CAPITA TARGET GROWTH
RATE.—For purposes of this section, the
Medicare per capita target growth rate for an
implementation year shall be calculated as
the projected 5-year average (ending with
such year) percentage increase in—
(i) the Consumer Price Index for All
Urban Consumers (all items; United States
city average), and
(II) the medical care expenditure cat-
egory of the Consumer Price Index for All
Urban Consumers (United States city aver-
age), and
(iii) any other factor with respect to a
determination year that is after 2017, the
nominal gross domestic product per capita plus
1.0 percentage point.

(7) SAVINGS REQUIREMENT.—
(A) IN GENERAL.—If, with respect to a
determination year, the Chief Actuary of the
Centers for Medicare & Medicaid Services
certifies that the proposal meets the require-
m ents of subparagraphs (A)(i) and (C) of
paragraph (2); and
(iv) a legislative proposal that imple-
ments the recommendations; and
(v) other information determined appro-
priate by the Board.

(2) PURSUANT TO CONCLUSION.—Upon receiving a proposal from the
Board under paragraph (3)(A)(i) or the Sec-
cretary under paragraph (5), the President
shall immediately submit such proposal to
Congress.

(5) CONTINGENT SECRETARIAL DEVELOP-
MENT OF PROPOSAL.—If, with respect to a
proposal, the Board, is required to, but
fails, to submit a proposal to the President
by the deadline applicable under paragraph
(3)(A)(i), the Secretary shall develop a de-
tailed and specific proposal that satisfies the
requirements of subparagraphs (A)(i) and (C)
and, to the extent feasible, subparagraph
(B) of paragraph (2) and contains the infor-
mation required paragraph (3)(B). By not
later than November 1, of the year, the Sec-
cretary shall transmit
(A) such proposal to the President; and

‘‘(4) REVIEW AND COMMENT BY THE SEC-
RETARY.—The Board shall submit a draft
copy of each proposal to be submitted to
Congress pursuant to the subsection to the
Secretary for the Secretary’s review and comment.
The Board shall submit such draft copy by
not later than September 1 of the determina-
tion year, and

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"(ii) the projected excess for the implementation year (expressed as a percent) determined under subparagraph (A).

(8) PER CAPITA RATE OF GROWTH IN NATIONAL HEALTH EXPENDITURES.—In the case of the per capita rate of growth in national health expenditures for the implementation year (beginning in 2018), the Chief Actuary of the Centers for Medicare & Medicaid Services shall project the per capita rate of growth in national health expenditures for the implementation year. Such rate of growth for an implementation year shall be calculated as the projected 5-year average annual percent increase in health care expenditures.

(C) CONGRESSIONAL CONSIDERATION.—

(1) INTRODUCTION.—

(A) IN GENERAL.—On the day on which a proposal is submitted to the President by the House or Senate, the legislative proposal (described in subparagraph (A) or (B)) contained in the proposal shall be introduced (by request) in the Senate by the majority leader of the Senate or by Members of the Senate designated by the majority leader of the Senate and shall be introduced (by request) in the House by the majority leader of the House or by Members of the House designated by the majority leader of the House.

(B) If either House is not in session on the day on which such legislative proposal is submitted, the legislative proposal shall be introduced in that House, as provided in paragraph (A), on the first day thereafter on which that House is in session.

(C) ANY MEMBER.—If the legislative proposal is not introduced in either House within 5 days on which that House is in session after the day on which the legislative proposal is submitted, then any Member of that House may introduce the legislative proposal.

(D) REFERRAL.—The legislation introduced under this paragraph shall be referred by the Presiding Officers of the respective Houses to the Committee on Finance in the Senate and to the Committee on Energy and Commerce of the House of Representatives.

(2) COMMITTEE CONSIDERATION OF PROPOSAL.—

(A) REPORTING BILL.—Not later than April 1 of any proposal year in which a proposal is submitted by the President to Congress under section 1909(a) of the Act for consideration by the Senate, the Committee on Finance shall report to the Senate the proposal pursuant to paragraph (1), accompanied by committee amendments related to the Medicare program.

(B) CALCULATIONS.—In determining whether Senate committee amendments meet the requirement of subparagraph (A), the reductions in Medicare program spending during the 3-month period immediately preceding the implementation year shall be counted to the extent that such reductions are a result of the implementation provisions in the committee amendment for a change in the payment rate for an item or service that was effective during such period pursuant to such amendment.

(C) COMMITTEE JURISDICTION.—Notwithstanding section 1909(c) of the Act, any determination by the Committee on Finance in the Senate that it has jurisdiction over the Medicare program contained in the proposal is a determination that the proposal is germane to the provisions of such bill.

(D) DISCHARGE.—If, with respect to the House of Representatives, the Speaker receives by the date required by subparagraph (A), the committee shall be discharged from further consideration of the proposal.

(3) LIMITATION ON CHANGES TO THE BOARD RECOMMENDATIONS.—

(A) IN GENERAL.—It shall not be in order in the Senate or the House of Representatives to consider any bill, resolution, or amendment pursuant to subparagraph (A), on the first business day after introduction but before disposition of such a bill in the receiving House, then the following shall apply:

(I) The question on passage shall be put on the bill of the other House as amended by the language of the receiving House.

(II) If a bill introduced pursuant to paragraph (i) is received by one House from the other House, after such a bill is passed by the receiving House, then the vote on passage of the bill that originates in the receiving House shall be considered to be the vote on passage of the bill received from the other House as amended by the language of the receiving House.

(B) LIMITATION.—Clauses (i), (ii), and (iii) shall apply only to a bill received by one House from the other House if the bill—

(I) is related only to the program under consideration, on the day such bill is received by one House from the other House.

(II) satisfies the requirements of subparagraphs (A)(i) and (C) of subsection (c)(2).

(C) SENATE LIMITS ON DEBATE.—

(i) IN GENERAL.—In the Senate, consideration of the bill and on all debatable motions and appeals in connection therewith shall not exceed a total of 30 hours, which shall be equally divided between, and controlled by, the majority and minority leaders or their designees.

(ii) MOTION TO FURTHER LIMIT DEBATE.—A motion to further limit debate on the bill is in order and is not debatable.

(iii) MOTION OR APPEAL.—Any debatable motion or appeal is debatable for not to exceed 1 hour, to be divided equally between the leaders favoring and those opposing the motion or appeal.

(iv) FINAL DISPOSITION.—After 30 hours of consideration, the Senate shall proceed, with or without further debate, to vote on the final disposition thereof to the exclusion of all amendments not then pending in the Senate, to the exclusion of all motions, except a motion to table, or to reconsider and one quorum call on demand to establish the presence of a quorum (and motions required to establish a quorum) immediately before the final vote begins.

(4) EXPEDITED PROCEDURE.—

(A) CONSIDERATION.—A motion to proceed to the consideration of the bill in the Senate is not debatable.

(B) AMENDMENT.—

(i) IN GENERAL.—Debate in the Senate on any amendment to a bill under this section shall be limited to 1 hour, to be equally divided between, and controlled by, the mover and the manager of the bill, and debate on any amendment to an amendment, debatable motion, or appeal shall be limited to 30 minutes, to be equally divided between, and controlled by, the mover and the manager of the bill, except that in the event the manager of the bill is in favor of any such amendment, motion, or appeal, the time in question shall be divided and controlled by the majority and minority leaders or their designees.

(ii) ADDITIONAL TIME.—The leaders, or either of them, may, from the time under their control, make not additional time to any Senator during the consideration of any amendment, debatable motion, or appeal.

(iii) VOTING.—A motion not in order.—It shall not be in order to consider an amendment that would cause the bill to result in a net reduction in total Medicare program spending during the implementation year that is less than the applicable savings target established under subsection (c)(7)(B) for such implementation year.

(iv) WAIVER AND APPEALS.—This paragraph may be waived or suspended in the Senate only by the affirmative vote of three-fifths of the Members, duly chosen and sworn.

(v) FINAL DISPOSITION.—After 30 hours of consideration of the bill and on all debatable motions and appeals in connection therewith shall not exceed a total of 30 hours, which shall be equally divided between, and controlled by, the majority and minority leaders or their designees.

(vi) LIMITATION.—Clauses (i), (ii), and (iii) shall apply only to a bill received by one House from the other House if the bill—

(I) is related only to the program under consideration, on the day such bill is received by one House from the other House.

(II) satisfies the requirements of subparagraphs (A)(i) and (C) of subsection (c)(2).

(D) WAIVER.—This paragraph may be

(i) TIME LIMITATION.—Debate in the Senate on any amendment under this paragraph shall be limited to 1 hour, to be equally divided between, and controlled by, the minority leader or such leader's designee.

(ii) VOTING.—A motion not in order.—It shall not be in order to consider an amendment that would cause the bill to result in a net reduction in total Medicare program spending during the implementation year that is less than the applicable savings target established under subsection (c)(7)(B) for such implementation year.

(iii) WAIVER AND APPEALS.—This paragraph may be waived or suspended in the Senate only by the affirmative vote of three-fifths of the Members, duly chosen and sworn. An affirmative vote of three-fifths of the Members of the Senate, duly chosen and sworn, shall be required in the Senate to sustain an appeal of the ruling of the Chair on a point of order raised under this paragraph.

(5) EXPEDITED PROCEDURE.—

(A) CONSIDERATION.—A motion to proceed to the consideration of the bill in the House is not debatable.

(B) AMENDMENT.—

(i) IN GENERAL.—Debate in the House on any amendment to a bill under this section shall be limited to 1 hour, to be equally divided between, and controlled by, the mover and the manager of the bill, and debate on any amendment to an amendment, debatable motion, or appeal shall be limited to 30 minutes, to be equally divided between, and controlled by, the mover and the manager of the bill, except that in the event the manager of the bill is in favor of any such amendment, motion, or appeal, the time in question shall be divided and controlled by the majority and minority leaders or their designees.

(ii) ADDITIONAL TIME.—The leaders, or either of them, may, from the time under their control, make not additional time to any Representative during the consideration of any amendment, debatable motion, or appeal.

(iii) VOTING.—A motion not in order.—It shall not be in order to consider an amendment that would cause the bill to result in a net reduction in total Medicare program spending during the implementation year that is less than the applicable savings target established under subsection (c)(7)(B) for such implementation year.

(iv) WAIVER AND APPEALS.—This paragraph may be waived or suspended in the Senate only by the affirmative vote of three-fifths of the Members, duly chosen and sworn. An affirmative vote of three-fifths of the Members of the House, duly chosen and sworn, shall be required in the House to sustain an appeal of the ruling of the Chair on a point of order raised under this paragraph.

(v) FINAL DISPOSITION.—After 30 hours of consideration, the House shall proceed, with or without further debate, to vote on the final disposition thereof to the exclusion of all amendments not then pending in the House, to the exclusion of all motions, except a motion to table, or to reconsider and one quorum call on demand to establish the presence of a quorum (and motions required to establish a quorum) immediately before the final vote begins.

(vi) CONSIDERATION IN CONFERENCE.—

(A) IN GENERAL.—In the Senate, consideration of the amendments and any messages between Houses shall be limited to 10 hours, equally divided between, and controlled by, the majority and minority leaders of the Senate or their designees and the Speaker of the House of Representatives and the minority leader of the House of Representatives or their designees.

(B) TIME LIMITATION.—Debate in the Senate on any amendment under this paragraph shall be limited to 1 hour, to be equally divided between, and controlled by, the majority and minority leaders of the Senate or their designees and the Speaker of the House of Representatives and the minority leader of the House of Representatives or their designees.

(C) COMMITTEE CONSIDERATION OF PROPOSAL.—

(A) REPORTING BILL.—Not later than April 1 of any proposal year in which a proposal is submitted by the President to Congress under section 1909(a) of the Act for consideration by the House, the Committee on Ways and Means shall report to the House the proposal pursuant to paragraph (1), accompanied by committee amendments related to the Medicare program.

(B) CALCULATIONS.—In determining whether House committee amendments meet the requirement of subparagraph (A), the reductions in Medicare program spending during the 3-month period immediately preceding the implementation year shall be counted to the extent that such reductions are a result of the implementation provisions in the committee amendment for a change in the payment rate for an item or service that was effective during such period pursuant to such amendment.

(C) COMMITTEE JURISDICTION.—Notwithstanding rule XV of the Standing Rules of the House, a committee amendment described in subparagraph (A) may include matter not within the jurisdiction of the Committee on Ways and Means if that matter is relevant to a proposal contained in the bill submitted under subsection (c)(3).

(D) DISCHARGE.—If, with respect to the House, the Speaker receives by the date required by subparagraph (A), the committee shall be discharged.
‘(ii) DEBATE LIMITATION.—In the Senate, consideration of the joint resolution, and on a motion to proceed thereto, shall be limited to not more than 10 hours, which shall be divided equally between the majority leader and the minority leader, or their designees. A motion further to limit debate in order and not debatable. An amendment to, or a motion to postpone, or a motion to reconsider the consideration of other business, or a motion to recommit the joint resolution is not in order.

‘(iii) PASSAGE.—In the Senate, immediately following the conclusion of the debate on a joint resolution described in paragraph (1), and a single quorum call at the conclusion of the debate if requested in accordance with the rules of the Senate, the vote on passage of the joint resolution shall occur.

‘(iv) APPEALS.—Appeals from the decisions of the Chair relating to the application of the rules of the Senate to the procedure relating to a joint resolution described in paragraph (1) shall be decided without debate.

‘(D) OTHER HOUSE ACTS FIRST.—If, before the passage by 1 House of a joint resolution of that House described in paragraph (1), that House receives from the other House a joint resolution described in paragraph (1), then the following procedures shall apply:

‘(1) the majority agreement report is not received from the other House;

‘(ii) With respect to a joint resolution described in paragraph (1) of the House receiving the joint resolution—

‘(1) the procedure in that House shall be in the same as if no joint resolution had been received from the other House; but

‘(i) that House considers the joint resolution—

‘(i) make any determinations under subparagraph (C) after May 1, 2017; or

‘(ii) not differently.

‘(C) the Board and the consumer advisory council under subsection (k) shall terminate on December 19, 2016.

‘(D) BOARD MEMBERSHIP; TERMS OF OFFICE; CHAIREPERSON; REMOVAL.—

‘(1) MEMBERSHIP.—

‘(i) 15 members appointed by the President, by and with the advice and consent of the Senate, to serve terms of 3 years each; and

‘(ii) The Secretary, the Administrator of the Center for Medicare & Medicaid Services,
and the Administrator of the Health Resources and Services Administration, all of whom shall serve ex officio as nonvoting members of the Board.

"(B) ETHICAL DISCLOSURE.—

"(i) IN GENERAL.—The appointed membership of the Board shall include individuals with national recognition for their expertise in health economics, health science, health facility management, health plans and integrated delivery systems, reimbursement of health facilities, allopathic and osteopathic physicians, and other providers of health services, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representa-

"(ii) INCLUSION.—The appointed membership of the Board shall include (but not be limited to) physicians and other health professionals, experts in the area of pharmaco-economics or prescription drug benefit programs, employers, third-party payers, individuals skilled in the conduct and interpretation of biomedical, health services, and health economics research and expertise in outcomes and effectiveness research and technology assessment. Such membership shall also include representatives of consumers and the elderly.

"(iii) STAFF.—The Board may be staffed by a professional staff of individuals who are directly involved in the provision or management of the delivery of items and services paid for under Title XVIII of the Social Security Act, providing expertise in general or specific areas.

"(iv) ECONOMIC EXPERTISE.—The members of the Board shall constitute a majority of the appointed membership of the Board.

"(C) ETHICAL DISCLOSURE.—

"(1) AUTHORITY TO INFORM RESEARCH PRIORITIES .—The Board may inform health services research, particularly as such priorities pertain to necessary changes and issues regarding payment reforms under Medicare. Such information to the Board on an agreed upon schedule.

"(2) TRAVEL EXPENSES .—The appointed members shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Board.

"(3) STAFF.—

"(i) IN GENERAL.—The Chairperson may, without regard to the civil service laws and regulations, appoint and terminate an executive director and such other additional personnel as may be necessary to enable the Board to perform its duties. The employment of an executive director shall be subject to confirmation by the Board.

"(ii) COMPENSATION.—The Chairperson may fix the compensation of the executive director and other personnel without regard to chapter 51 and subchapter III of chapter 53 of title 5, United States Code, relating to classification of positions and General Schedule pay rates, except that the rate of pay for the executive director and other personnel may not exceed the rate prescribed for level V of the Executive Schedule under section 5316 of such title.

"(4) DETAIL OF GOVERNMENT EMPLOYEES.—Any Federal Government employee may be detailed to the Board without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

"(5) PROCUREMENT OF TEMPORARY AND INTERMITTENT SERVICES.—The Chairperson may procure temporary and intermittent services under section 3109(b) of title 5, United States Code, at rates for individuals which do not exceed the daily equivalent of the annual rate of basic pay prescribed for level V of the Executive Schedule under section 5316 of such title.

"(K) CONSUMER ADVISORY COUNCIL.—

"(L) MEMBERSHIP.—

"(A) NUMBER AND APPOINTMENT.—

"(i) IN GENERAL.—The consumer advisory council shall be composed of 10 consumer representatives appointed by the Comptroller General of the United States, 1 from among each of the 10 regions established by the Secretary as of the date of enactment of this section.

"(B) QUALIFICATIONS.—

"(i) IN GENERAL.—The membership of the council shall represent the interests of consumers and particular communities.

"(ii) OPEN MEETINGS.—Meetings of the consumer advisory council shall be open to the public.

"(E) VOTE OF OFFICERS.—

"(i) IN GENERAL.—The terms ‘Board’, ‘Chairperson’, and ‘Member’ mean the Independent Medicare Advisory Board.
(B) REPORT.—Not later than July 1, 2015, the Comptroller General shall submit to Congress a report containing the results of the study conducted under subparagraph (A), including recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

(2) SUBSEQUENT STUDIES AND REPORTS.—The Comptroller General may conduct such additional studies and submit reports to Congress on changes to Medicare payment policies, methodologies, and rates and coverage policies and methodologies as the Comptroller General determines appropriate, in consultation with the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate.

(c) CONFORMING AMENDMENTS.—Section 1805(b) of the Social Security Act (42 U.S.C. 1805(b)-6(b)) is amended—

(1) by redesignating paragraphs (4) through (8) as paragraphs (5) through (9), respectively;

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

‘‘(4) REVIEW AND COMMENT ON THE INDEPENDENT MEDICARE ADVISORY BOARD OR SECRETARIAT PROPOSAL.—If the Independent Medicare Advisory Board (as established under subpart (a) of section 1899A) or the Secretariat conducts a study in consultation with the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate written comments on such proposal. Such comments may include such recommendations as the Commission deems appropriate.’’.

Subtitle F—Health Care Quality Improvements

SEC. 3501. HEALTH CARE DELIVERY SYSTEM RESEARCH; QUALITY IMPROVEMENT TECHNICAL ASSISTANCE.

Part D of title IX of the Public Health Service Act, as amended by section 3013, is further amended by adding at the end the following:

‘‘Subpart II—Health Care Quality Improvement Programs

SEC. 3523. HEALTH CARE DELIVERY SYSTEM RESEARCH.

(a) PURPOSE.—The purposes of this section are to—

(1) enable the Director to identify, develop, and provide training in innovative methodologies and strategies for quality improvement practices in the delivery of health care services that represent best practices (referred to as ‘‘best practices’’) in health care quality, safety, and value; and

(2) ensure that the Director is accountable for implementing a model to pursue such research in a collaborative manner with other related Federal agencies.

(b) GENERAL FUNCTIONS OF THE CENTER.—The Center for Quality Improvement and Patient Safety of the Agency for Healthcare Research and Quality (referred to in this section as the ‘‘Center’’), or any other relevant agency or department designated by the Director, shall—

(1) carry out its functions using research from a variety of disciplines, which may include activities for the examination of strategies to improve patient safety, quality improvement practices in the delivery of health care services and the development of tools to facilitate adoption of best practices
that improve the quality, safety, and efficiency of health care delivery services. Such support may include establishing a Quality Improvement Network Research Program for the purpose of testing, scaling, and disseminating of interventions to improve quality and efficiency in health care. Recipients of funding under the Program may include national, State, local, and multi-site quality improvement networks.

(2) RESEARCH REQUIREMENTS.—The research conducted pursuant to paragraph (1) shall—

(A) address the priorities identified by the Secretary in the national strategic plan established under section 399HH; and

(B) identify areas in which evidence is insufficient to identify strategies and methodologies, taking into consideration areas of insufficient evidence identified by the entity with a contract under section 1890(a) of the Social Security Act in the report required under section 399J;

(C) address concerns identified by health care institutions and providers and communicated through the Center pursuant to subsection (d);

(D) reduce preventable morbidity, mortality, and costs of morbidity and mortality by building capacity for patient safety research;

(E) support the discovery of processes for the rapid, safe, efficient, and responsive delivery of health care, taking into account discoveries from clinical research and comparative effectiveness research;

(F) allow communication of research findings and translate evidence into practice recommendations that are adaptable to a variety of settings, and which, as soon as practically feasible after the establishment of the Center, shall include—

(i) the implementation of a national application of Intensive Care Unit improvement and practices described under paragraphs (1) and (2) to the adult, pediatric, geriatric, and neonatal patient populations;

(ii) practical methods for addressing health care associated infections, including Methicillin-Resistant Staphylococcus Aureus and Vancomycin-Resistant Enterococcus infections and other emerging infectious diseases;

(iii) practical methods for reducing preventable hospital admissions and readmissions;

(G) expand demonstration projects for improving the quality of children’s health care and the use of health information technology, such as through Pediatric Quality Improvement Collaboratives and Learning Networks, consistent with provisions of section 1139A of the Social Security Act for assessing and improving quality, where applicable;

(H) identify and mitigate hazards by—

(i) analyzing events reported to patient safety reporting systems and patient safety organizations; and

(ii) using the results of such analyses to develop scientific methods of response to such events;

(I) include the conduct of systematic reviews of existing practices that improve the quality, safety, and efficiency of health care delivery, as well as new research on improving such practices; and

(J) include the examination of how to measure and evaluate the progress of quality and patient safety activities.

(3) DISSEMINATION OF RESEARCH FINDINGS.—

(A) IN GENERAL.—The Director, through the Center for Quality Improvement and Patient Safety of the Agency for Healthcare Research and Quality (referred to in this section as the ‘‘Center’’), shall make available (directly or through consortia and other entities) or provide assistance to health care institutions and providers, including hospitals, health plans, and other health care settings, to disseminate research findings, including—

(i) comparative effectiveness research;

(ii) discoveries from clinical research and collaborative networks; and

(iii) scientific methods of response to hazards identified in health care delivery.

(B) ELIGIBLE ENTITIES.—To be eligible to receive a technical assistance award, an entity—

(i) may be a health care provider, health care provider association, professional society, health care worker organization, Indian health organization, quality improvement organization, patient safety organization, local quality improvement collaborative, a Joint Commission, academic health center, university, physician-based research network, or other entity identified by the Secretary as appropriate for the provision of technical assistance to health care providers.

(C) EVALUATION.—The evaluation of an entity shall include—

(i) the conduct of a study of the impact of the implementation of a model or practice identified in the research conducted by the Center including—

(I) financial cost, staffing requirements, and timeline for implementation; and

(ii) pre- and post-implementation quality measure performance data in targeted improvement areas identified by the Secretary; and

(D) MATCHING FUNDS.—The Director 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 this section, 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 an entity identified by the Director as having the capability to provide such funds, and may be in cash or in-kind, fairly evaluated, including plant, equipment, or services.

(4) EVALUATION.—

(A) IN GENERAL.—The Director shall evaluate the performance of each entity that receives a grant or contract under this section. The evaluation of an entity shall include a study of—

(i) the success of such entity in achieving the implementation, by the health care institutions and providers assisted by such entity, of the models and practices identified in the research conducted by the Center under section 399J;

(ii) the perception of the health care institutions and providers assisted by such entity regarding the value of the entity; and

(iii) the impact of the entity on patient health outcomes and lower cost resulting from the assistance provided by such entity.

(B) EFFECT OF EVALUATION.—Based on the outcome of the evaluation of the entity under paragraph (1), the Director shall determine whether to renew a grant or contract with such entity under this section.
technology regional extension centers under section 3012(c) and the primary care extension program established under section 399W regarding the dissemination of quality improvement strategies and tools.

SEC. 2502. ESTABLISHING COMMUNITY HEALTH TEAM TO SUPPORT THE PATIENT-CENTERED MEDICAL HOME.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ‘Secretary’) shall establish a program to provide grants to or enter into contracts with eligible entities to establish community-based interdisciplinary, interprofessional teams (referred to in this section as ‘health teams’) to support primary care practices, including obstetrics and gynecology practices, within the hospital service area of the eligible entities. Grants or contracts shall be used to—

(1) establish health teams to provide support services to primary care providers; and

(2) provide capitated payments to primary care providers as determined by the Secretary.

(b) ELIGIBLE ENTITIES.—To be eligible to receive a grant or contract under subsection (a), an entity shall—

(1)(A) be a State or State-designated entity;

(B) be an Indian tribe or tribal organization, as defined in section 4 of the Indian Health Care Improvement Act;

(2) be establishing achieving long-term financial sustainability within 3 years;

(3) submit a plan for incorporating prevention initiatives and patient education and care coordination into the delivery of health care that is integrated with community-based prevention and treatment resources, where available;

(4) ensure that the health team established by the entity includes an interdisciplinary, interprofessional team of health care providers, as determined by the Secretary; such team may include medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral and mental health providers (including substance use disorder prevention and treatment providers), doctors of chiropractic, licensed complementary and alternative medicine practitioners, and physicians’ assistants;

(5) provide services to eligible individuals with chronic conditions, as described in section 1945 of the Social Security Act (as added by section 270B), in accordance with the requirements established under subsection (c) of such section; and

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

(c) REQUIREMENTS FOR HEALTH TEAMS.—A health team established pursuant to a grant or contract under subsection (a) shall—

(1) establish contractual agreements with primary care providers to provide support services;

(2) support patient-centered medical homes, defined as a mode of care that includes—

(A) personal physicians;

(B) whole person orientation;

(C) coordinated and integrated care;

(D) safe and high-quality care through evidence-informed medicine, appropriate use of health information technology, and continuous quality improvements;

(E) expanded access to care; and

(F) recognizes added value from additional components of patient-centered care;

(3) collaborate with local primary care providers, as determined by the Secretary, to identify eligible entities and to coordinate with the eligible entities to coordinate disease prevention, chronic disease management, transitioning between health care providers and settings and case management for patients, including children, with priority given to those amenable to prevention and health promotion services for chronic diseases or conditions identified by the Secretary;

(4) in collaboration with local health care providers, develop and implement interdisciplinary care plans that integrate clinical and community preventive and health promotion services for patients, including children, with priority given to those amenable to prevention and with chronic diseases or conditions identified by the Secretary;

(5) incorporate health care providers, patients, caregivers, and authorized representatives in program design and oversight;

(6) provide support necessary for local primary care network.

(A) coordinate and provide access to high-quality health care services; and

(B) coordinate and provide access to preventive and health promotion services;

(C) provide access to appropriate specialty care and inpatient services;

(D) provide quality-driven, cost-effective, culturally appropriate, and patient- and family-centered health care;

(E) provide access to pharmacist-delivered medication management services, including medication reconciliation;

(F) provide coordination of the appropriate use of complementary and alternative (CAM) services through such services;

(G) promote effective strategies for treatment planning, monitoring health outcomes and resource use, sharing information, treatment decision support, and organizing care to avoid duplication of service and other medical management approaches intended to improve quality and value of health care services;

(H) provide local access to the continuum of health care services in the most appropriate setting, including access to individuals that implement the care plans of patients and coordinate care, such as integrative health care practitioners;

(I) collect and report data that permits evaluation of the success of the collaborative effort on patient outcomes, including collection of data on patient experience of care, and identification of areas for improvement; and

(J) establish a coordinated system of early identification and referral for children at risk for developmental or behavioral problems such as through the use of infolines, health information technology, or other means as determined by the Secretary;

(7) provide 24-hour care management and support during transitions in care settings including—

(A) a transitional care program that provides for discharge planning, medication reconciliation, and collaboration with the discharge and pharmacy services, as described in subsection (e); and

(B) discharge planning and counseling support to providers, patients, caregivers, and authorized representatives;

(C) assure that post-discharge care plans include medication management, as appropriate;

(D) referrals for mental health and behavioral health services, which may include the use of infolines; and

(E) transitional health care needs from adolescence to adulthood;

(8) serve as a liaison to community preventive and treatment programs;

(9) demonstrate a capacity to implement and maintain health information technology (HIT) that is certified by EHR technology (as defined in section 3000 of the Public Health Service Act (42 U.S.C. 300jj)) to facilitate coordination among members of the applicable care team and affiliated primary care practices; and

(10) where applicable, provide to the Secretary information on the measures used under section 399J of the Public Health Service Act.

(d) REQUIREMENT FOR PRIMARY CARE PROVIDER.—A provider who contracts with a care team shall—

(1) provide a care plan to the care team for each patient participant;

(2) provide access to participant health records; and

(3) meet regularly with the care team to ensure integration.

(e) REPORTING TO SECRETARY.—An entity that receives a grant or contract under subsection (a) shall submit to the Secretary a report that describes and evaluates, as requested by the Secretary, the activities carried out by the entity under subsection (c).

DEFINITION OF PRIMARY CARE.—In this section, the term ‘primary care’ means the provision of integrated, accessible health care services by clinicians who are accountable for continuous, comprehensive care of an identifiable, interdependent group of patients, and the provision of care to patients, caregivers, and authorized representatives.

SEC. 3503. MEDICATION MANAGEMENT SERVICES IN TREATMENT OF CHRONIC DISEASE.

Title IX of the Public Health Service Act (42 U.S.C. 299 et seq.), as amended by section 3501, is further amended by inserting after subsection (b) the following:

SEC. 935. GRANTS OR CONTRACTS TO IMPLEMENT MEDICATION MANAGEMENT SERVICES IN TREATMENT OF CHRONIC DISEASES.

(a) IN GENERAL.—The Secretary, acting through the Patient Safety Research Center established in section 399EE of this title (referred to in this section as the ‘Center’), shall establish a program to provide grants or contracts to eligible entities to implement medication management services in treatment of chronic diseases.

(b) ELIGIBLE ENTITIES.—To be eligible to receive a grant or contract under subsection (a), an entity shall—

(1) provide a setting appropriate for MTM services, as recommended by the experts described in subsection (c);

(2) submit to the Secretary a plan for achieving long-term financial sustainability; and

(3) where applicable, submit a plan for coordinating MTM services through local community health teams established in section 3002 of the Patient Protection and Affordable Care Act or in collaboration with primary care extension programs established in section 399W.

(4) submit a plan for meeting the requirements under subsection (c); and

(5) submit to the Secretary such other information as the Secretary may require.

(c) MTM SERVICES TO TARGETED INDIVIDUALS.—The MTM services provided by licensed pharmacists, as a collaborative, multidisciplinary, interprofessional approach to the treatment of chronic diseases targeted individuals, to improve the quality of care and reduce overall cost in the treatment of chronic diseases. The Secretary shall ensure that the program under this section not later than May 1, 2010.

(1) MTM SERVICES TO TARGETED INDIVIDUALS.—The MTM services provided by licensed pharmacists, as a collaborative, multidisciplinary, interprofessional approach to the treatment of chronic diseases targeted individuals, to improve the quality of care and reduce overall cost in the treatment of chronic diseases.

(2) PROVIDER.—The MTM services provided by licensed pharmacists, as a collaborative, multidisciplinary, interprofessional approach to the treatment of chronic diseases targeted individuals, to improve the quality of care and reduce overall cost in the treatment of chronic diseases.
upon by the prescriber and the patient or caregiver or authorized representative of the patient;

(3) selecting, initiating, modifying, recommending, or administering medication therapy;

(4) monitoring, which may include access to, ordering, or performing laboratory assessments related to the response of the patient to therapy, including safety and effectiveness;

(5) performing an initial comprehensive medication review with the goal of identifying, resolving, and preventing medication-related problems, including adverse drug events, quarterly targeted medication reviews for ongoing monitoring, and a gap in therapy identification schedule developed collaboratively with the prescriber;

(6) documenting the care delivered and communicating essential information about such care, including a summary of the medication review, and the recommendations of the pharmacist to other appropriate health care providers of the patient in a timely fashion;

(7) providing education and training designed to enhance the understanding and appropriate medication management for the patient, caregiver, and other authorized representatives;

(8) providing information, support services, and strategies designed to enhance patient adherence with therapeutic regimens;

(9) coordinating and integrating MTM services within the broader health care management services provided to the patient; and

(b) such other patient care services allowed under pharmacist scopes of practice in use in other Federal programs that have implemented MTM services.

(1) take 4 or more prescribed medications (including over-the-counter medications and dietary supplements);

(2) take any ‘high risk’ medications;

(3) have 2 or more chronic diseases, as identified by the Secretary; or

(4) have undergone a transition of care, or other factors, as determined by the Secretary, that are likely to create a high risk of medication-related problems.

(2) §3503. Consultation With Experts.—In designing and implementing MTM services provided under grants or contracts awarded under subsection (a), the Secretary shall consult with Federal, State, private, public, academic, institutional, pharmacy and pharmacist organizations, health care providers, consumer advocates, chronic disease groups, and other stakeholders involved with the research, dissemination, and implementation of pharmacist-delivered MTM services, as the Secretary determines appropriate. The Secretary, in collaboration with such group, shall determine whether it is possible to incorporate rapid cycle process improvement concepts in use in other Federal programs that have implemented MTM services.

(3) §3504. Design and Implementation of Regionalized Systems for Emergency Care.—

(a) In General.—Title XII of the Public Health Service Act (2 U.S.C. 200d et seq.) is amended—

(1) in section 1203—

A. in the section heading, by inserting ‘‘FOR TRAUMA SYSTEMS’’ after ‘‘GRANTS’’; and

B. in subsection (a), by striking ‘‘Administrator of the Health Resources and Services Administration’’ and inserting ‘‘Assistant Secretary for Preparedness and Response’’;

(2) by inserting after section 1203 the following:

SEC. 1204. COMPETITIVE GRANTS FOR REGIONALIZED SYSTEMS FOR EMERGENCY CARE RESPONSIBILITY.

(a) In General.—An eligible entity that seeks a contract or grant described in subsection (a) shall submit to the Secretary an application at such time and in such manner as the Secretary may require.

(b) Grant Information.—Each application shall include—

(A) an assurance from the eligible entity that the proposed system—

(i) has been coordinated with the applicable State Office of Emergency Medical Services (or equivalent State office);

(ii) includes consistent, direct, and indirect medical oversight of prehospital, hospital, and inter-facility transport throughout the region;

(iii) coordinates prehospital transport and triage, hospital destination, and inter-facility transport throughout the region;

(iv) includes a categorization or designation system for special medical facilities throughout the region that is integrated with transport and destination protocols;

(v) includes a regional medical direction, prehospital tracking, and resource allocation system that supports day-to-day emergency care and surge capacity and is integrated with other components of the national and State emergency preparedness system; and

(vi) addresses pediatric concerns related to integration, planning, preparedness, and coordination of emergency medical services for infants, children, and adolescents; and

(B) such other information as the Secretary may require.

(c) REQUIREMENT OF MATCHING FUNDS.—

(1) In General.—The Secretary must not make a grant under this section unless the State (or consortia of States) involved agrees, with respect to the costs to be incurred by the State (or consortia) in carrying out the purpose for which such grant is intended, to make available non-Federal contributions (in cash or in kind under paragraph (2)) toward such costs in an amount
equal to not less than $1 for each $3 of Federal funds provided in the grant. Such contributions may be made directly or through donations from public or private entities.

"(2) NON-FEDERAL CONTRIBUTIONS.—Non-Federal contributions required in paragraph (1) may be in cash or in kind, fairly evaluated, including equipment or services (and excluding any interest on such contributions). Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such non-Federal contributions.

"(f) Priority.—The Secretary shall give priority for the award of the contracts or grants described in subsection (a) to any eligible entity that serves a population in a medically underserved area (as defined in section 330(b)(3)).

"(g) Report.—Not later than 90 days after the completion of a pilot project under subsection (a), the recipient of such contract or grant described in subsection (a) shall submit to the Secretary a report containing the results of an evaluation of the program, including an identification of—

"(1) the impact of the regional, accountable emergency care and trauma system on patient health outcomes for various critical care emergency and trauma patients, such as cardiac emergencies, neurologic emergencies, and pediatric emergencies;

"(2) the system characteristics that contribute to the financial sustainability of the emergency care and trauma system;

"(3) the State and local legislation necessary to implement and maintain the system;

"(4) the barriers to developing regionalized, accountable emergency care and trauma systems, as well as the methods to overcome such barriers; and

"(5) recommendations on the utilization of available funding for future regionalization efforts.

"(h) Dissemination of Findings.—The Secretary shall, as appropriate, disseminate to the public and to the appropriate Committees of the Congress, the information contained in a report made under subsection (g).

"(i) Section 3505. Trauma Care Centers and Service Availability.

"(a) Trauma Care Centers.—

"(1) Establishment of Trauma Care Centers.—Section 1241 of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1318 et seq.) is amended by striking subsections (a)(1) and (b) and inserting the following:

"(A) GENERAL.—The Secretary shall establish 3 programs to award grants to qualified public, nonprofit Indian Health Service, Indian tribal, and urban Indian trauma centers—

"(i) to assist in defraying substantial uncompensated care costs; (ii) to further the core missions of such trauma centers, including by addressing costs associated with patient stabilization and transfer, trauma education and outreach, coordination, development and administration of trauma systems, essential personnel and other fixed costs, and expenses associated with employee and non-employee physician services; and

"(3) to provide emergency relief to ensure the continued and future availability of trauma centers.

"(b) Minimum Qualifications of Trauma Centers.—

"(1) Participation in Trauma Care System Operating Under a Corporate Professional Guidelines.—Except as provided in paragraph (2), the Secretary may not award a grant to a trauma center under subsection (a)(1) unless such center—

"(1) participates in a trauma care system that substantially complies with section 1213.

"(2) Exemption.—Paragraph (1) shall not apply to trauma centers that are located in States with no existing trauma care system.

"(3) Qualification for Substantial Uncompensated Care Costs.—The Secretary shall award substantial uncompensated care grants under subsection (a)(1) only to trauma centers meeting at least 1 of the criteria in each of the following 3 categories:

"(A) Category A.—The criteria for category A are as follows:

"(i) At least 40 percent of the visits in the emergency department of the hospital in which the trauma center is located were charity or self-pay patients.

"(ii) At least 50 percent of the visits in such emergency department were Medicaid (under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.)) and charity and self-pay patients combined.

"(B) Category B.—The criteria for category B are as follows:

"(i) At least 35 percent of the visits in the emergency department were charity or self-pay patients.

"(ii) At least 50 percent of the visits in the emergency department were Medicaid and charity and self-pay patients combined.

"(C) Category C.—The criteria for category C are as follows:

"(i) At least 20 percent of the visits in the emergency department were charity or self-pay patients.

"(ii) At least 30 percent of the visits in the emergency department were Medicaid and charity and self-pay patients combined.

"(4) Trauma Centers in NCI Waiver States.—Notwithstanding paragraph (3), the Secretary may award a substantial uncompensated care grant to a trauma center under subsection (a)(1) if the trauma center qualifies for funds under a Low Income Pool Net Care Program through a waiver approved under section 1115 of the Social Security Act (42 U.S.C. 1315).

"(5) Designation.—The Secretary may not award a grant to a trauma center under subsection (a)(1) unless such trauma center—

"(i) submits to the Secretary a plan satisfactory to the Secretary that demonstrates a continued commitment to serving trauma patients regardless of their ability to pay; and

"(ii) has policies in place to assist patients who cannot pay for part or all of the care they receive, including a sliding fee scale, and to ensure fair billing and collection practices.

"(2) Considerations in Making Grants.—

"(A) General.—The Secretary may award a grant to a trauma center under subsection (a)(1) only to such center—

"(i) submits to the Secretary a plan satisfactory to the Secretary that demonstrates a continued commitment to serving trauma patients regardless of their ability to pay;

"(ii) is not located in a State that has a trauma center that is located in a State with an existing trauma care system;

"(iii) applies for and accepts the grant.

"(B) Restrictions.—The applicable percentages are as follows:

"(1) With respect to a category A trauma center, 100 percent of the uncompensated care costs are eligible for funding.

"(2) With respect to a category B trauma center, not more than 75 percent of the uncompensated care costs.

"(3) With respect to a category C trauma center, not more than 50 percent of the uncompensated care costs.

"(3) Grants for Trauma Care Centers.—

"(1) In General.—The Secretary shall establish a grant program for trauma care centers through which grants under subsection (a)(1) are made.

"(2) Priority.—The Secretary shall give priority to grants to trauma care centers—

"(A) located in States with no existing trauma care system;

"(B) located in States that have fewer than 2 trauma care centers; and

"(C) located in rural or frontier areas.

"(B) Additional Requirements.—

"(1) Performance-Based Requirements.—A grant under this subsection is contingent upon the trauma center—

"(i) submitting a plan satisfactory to the Secretary that demonstrates a continued commitment to serving trauma patients regardless of their ability to pay; and

"(ii) having policies in place to assist patients who cannot pay for part or all of the care they receive, including a sliding fee scale, and to ensure fair billing and collection practices.

"(2) Dissemination of Findings.—The Secretary shall disseminate to the public and to the appropriate Committees of the Congress the information contained in a report made under subsection (g).
(b) Core Mission Awards.—

"(1) In general.—In awarding grants under section 1241(a)(2), the Secretary shall—

(A) reserve 25 percent of the amount allocated to grants for core Level III and Level IV trauma centers; and

(B) reserve 25 percent of the amount allocated for core mission awards for large urban Level I trauma centers.

"(2) Emergency Awards.—(A) In awarding grants under section 1241(a)(3), the Secretary shall—

(1) give preference to any application submitted by a trauma center that provides trauma services in an area in which the availability of trauma care has significantly decreased or will significantly decrease if the center is forced to close or downsize; or

(2) reallocate any emergency awards funds not obligated due to insufficient, or a lack of, applications to the signatory geographic area in which the availability of trauma care services exceeds capacity; and

"(3) Consideration.—(A) Consideration under section 1241(a) to maintain access to trauma services at comparable levels to the prior year during the grant period.

(b) Trauma Care Registry.—The Secretary may require the trauma center receiving a grant under section 1241(a) to provide data to a national and centralized registry of trauma cases, in accordance with guidelines developed by the American College of Surgeons, and the Secretary may otherwise require.

(c) Limitation on Amount of Grant.—Notwithstanding section 1242(a), a grant under section 1241 may not be made in an amount exceeding $2,000,000 for each fiscal year.

(d) Eligibility.—Except as provided in section 1242(b)(1)(B)(ii), acquisition of, or eligibility under section 1241(a)(3) shall not preclude a trauma center from being eligible for other grants described in this part.

(e) Funding Distribution.—Of the total amount appropriated for a fiscal year under section 1245, 70 percent shall be used for substantial uncompensated care awards under section 1241(a)(1), 20 percent shall be used for core mission awards under section 1241(a)(2), and 10 percent shall be used for substantial uncompensated care awards under section 1241(a)(3).

(f) Minimum Allowance.—Notwithstanding subsection (e), if the amount appropriated under section 1245 is less than $25,000,000, all available funding for such fiscal year shall be used for substantial uncompensated care awards under section 1241(a).

(g) Substantial Uncompensated Care Award Distribution and Proportional Share.—Notwithstanding section 1242(a), of the amount appropriated under section 1245, the Secretary shall—

(1) make available a grant under section 1241(a) to provide funding to States to enable such trauma centers and trauma-related hospitals and emergency medical services personnel related to trauma care to collaborate.

(2) Promote trauma care collaboration.

(3) Provide funding to States to enable such trauma centers and trauma-related hospitals and emergency medical services personnel related to trauma care to collaborate.

(4) Include trauma care services for which demand is exceeded.

(5) Special considerations.

(6) Limitation.

(i) In general.—A State that provides trauma care services for which demand is exceeded shall—

(A) be—

(1) Providing trauma centers with funding for trauma care services for which demand is exceeded; and

(2) Providing trauma centers with funding for trauma care services for which demand is exceeded.

(ii) Limitation.

(A) To be eligible to receive a grant under subsection (b) an entity shall—

(iii) Meet the requirements of paragraphs (1), (2), and (5) of section 1241(b).

(iii) a safety net public or nonprofit trauma center that meets the requirements of paragraphs (1) through (5) of section 1241(b); or

(iv) a hospital in an underserved area (as defined by the State) that seeks to establish new trauma services; and

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

(4) Limitation.—A State shall use at least 40 percent of the funds awarded to the State under this part for a fiscal year to award grants to safety net trauma centers described in paragraph (1)(A)(ii).

(5) Use of Funds.—The recipient of a grant under subsection (b) shall carry out one or more of the following activities consistent with subsection (b):

(1) Providing trauma centers with funding to support physician compensation in trauma-related physician specialties where shortages exist in the region involved, with priority provided to safety net trauma centers described in subsection (c)(1)(A)(ii).

(2) Providing for individual safety net trauma center fiscal stability and costs related to having sustained 24 hours a year, 7 days a week, priority provided to safety centers described in subsection (c)(1)(A)(ii) located in urban, border, and rural areas.

(3) Reducing trauma center overcrowding at specific trauma centers related to the throughput of trauma patients.

(4) Establishing new trauma services in underserved areas as defined by the State.

(5) Enhancing collaboration between trauma centers and other hospitals and emergency medical services personnel related to trauma service availability.

(6) Making capital improvements to enhance access and expedite trauma care, including providing helipads and associated safety infrastructure.

(7) Enhancing trauma surge capacity at specific trauma centers.

(8) Ensuring expedient receipt of trauma patients transported by ground or air to the appropriate trauma center.

(9) Enhancing interstate trauma center collaboration.

(6) Limitation.—

"(1) In general.—A State may use not more than 20 percent of the amount available for a State under this part for a fiscal year for administrative costs associated with awarding grants and related costs.

(2) Limitation.—A State shall use at least 40 percent of the funds awarded to the State under this part for a fiscal year to award grants to States that have 1 or more trauma centers eligible for funding under section 1241(b)(3).

(7) Distribution of Funds.—The following shall apply with respect to grants provided in this part:

(1) Less than $10,000,000.—If the amount of appropriations for this fiscal year in a fiscal year is less than $10,000,000, the Secretary shall divide such funding among grants provided in this part for a fiscal year for administrative costs associated with awarding grants and related costs.

(8) Limitation.—A State shall use at least 40 percent of the funds awarded to the State under this part for a fiscal year to award grants to States that have 1 or more trauma centers eligible for funding under section 1241(b)(3).
"(3) LESS THAN $30,000,000.—If the amount of appropriations for this part in a fiscal year is less than $30,000,000, the Secretary shall divide such funding evenly among only those States that have one or more trauma centers eligible for funding under section 1241(b)(3).

"(4) $30,000,000 OR MORE.—If the amount of appropriations for this part in a fiscal year is $30,000,000 or more, the Secretary shall divide such funding evenly among all States.

"SEC. 1282. AUTHORIZATION OF APPROPRIATIONS.—

"For the purpose of carrying out this part, there is authorized to be appropriated $100,000,000 for each of fiscal years 2010 through 2015."

"SEC. 3506. PROGRAM TO FACILITATE SHARED DECISION-MAKING.—

Part D of title IX of the Public Health Service Act, as amended by section 3505, is further amended by adding at the end the following:

"SEC. 3506. PROGRAM TO FACILITATE SHARED DECISION-MAKING.—

"(a) PURPOSE.—The purpose of this section is to facilitate collaborative processes between patients, caregivers or authorized representatives, and clinicians that engages the patient, caregiver or authorized representative in decisionmaking, provides patients, caregivers or authorized representatives with information about trade-offs among treatment options, and facilitates the incorporation of patient preferences and values into the medical plan.

"(b) DEFINITIONS.—In this section:

"(1) PATIENT DECISION AID.—The term ‘patient decision aid’ means an educational tool that helps patients, caregivers or authorized representatives understand and communicate their beliefs and preferences related to their treatment options, and to decide with their health care provider what treatments are best for them based on their treatment preferences or values.

"(2) PREFERENCE SENSITIVE CARE.—The term ‘preference sensitive care’ means medical care for which the clinical evidence does not clearly support one treatment option over another, such that the appropriate course of treatment depends on the values of the patient or the preferences of the patient, caregiver or authorized representative.

"(3) ESTABLISHMENT OF INDEPENDENT STANDARDS FOR SCIENTIFIC EVIDENCE FOR PREFERENCE SENSITIVE CARE.—

"(1) CONTRACT WITH ENTITY TO ESTABLISH STANDARDS.—

"(a) IN GENERAL.—The Secretary, acting through the Director, and in coordination with heads of other relevant agencies, such as the Director of the Centers for Disease Control and Prevention and the Director of the National Institutes of Health, shall establish a program to award grants or contracts—

"(i) to develop, update, and produce patient decision aids for preference sensitive care; and

"(ii) to develop, update, and produce patient decision aids for preference sensitive care.

"(b) REQUIREMENTS FOR PATIENT DECISION AIDS.—Patient decision aids developed pursuant to a grant or contract under paragraph (1) shall—

"(A) be designed to engage patients, caregivers, and authorized representatives in informed decisionmaking with health care providers;

"(B) present updated clinical evidence about the risks and benefits of treatment options in a form and manner that is understandable and age-appropriate to the informed patient or his or her authorized representative.

"(C) LIMITATION.—Funds under this paragraph shall not be used to purchase or implement use of patient decision aids other than those certified under the process identified in subsection (c).

"(D) PRESENTATION OF PRESCRIPTION DRUG BENEFIT AND RISK INFORMATION.—

"(1) IN GENERAL.—The Secretary of Health and Human Services shall develop, update, and produce consumer labels for prescription drugs that include information about the risks and benefits of available treatment options, including information about the relative effectiveness (including possible risks), health outcomes and impact on functional status, and relative cost of treatment or, where appropriate, palliative care options;

"(2) NONDUPLICATION OF EFFORTS.—The Director shall ensure that the activities under this section do not duplicate the efforts of any other Federal agency or organization;

"(3) FUNDING.—For purposes of carrying out this section there are authorized to be appropriated such sums as may be necessary for fiscal year 2010 and each subsequent fiscal year.

"SEC. 3507. PRESENTATION OF PRESCRIPTION DRUG BENEFIT AND RISK INFORMATION.—

"(a) IN GENERAL.—The Secretary of Health and Human Services shall develop, update, and produce consumer labels for prescription drugs that include information about the risks and benefits of available treatment options, including information about the relative effectiveness (including possible risks), health outcomes and impact on functional status, and relative cost of treatment or, where appropriate, palliative care options.

"(b) REVIEW AND CONSULTATION.—In making the determination under subsection (a), the Secretary shall review all available scientific evidence about the risks and benefits of prescription drugs and consult with drug manufacturers, clinicians, patients and consumers, experts in health literacy, representatives of racial and ethnic minorities, and experts in women’s and pediatric health.

"SEC. 3508. IMPLEMENTATION.—

"(1) IN GENERAL.—The Secretary shall establish a program to provide for the phased-in implementation, in collaboration with clinicians and patients or their representatives, and evaluation of shared decisionmaking using patient decision aids to meet the objective of improving the understanding of patients of their medical treatment options.

"(2) SHARED DECISION-MAKING RESOURCE CENTERS.—

"(A) IN GENERAL.—The Secretary shall provide for the establishment and support of Shared Decision-making Resource Centers (referred to in this subsection as ‘Centers’). The Secretary shall provide assistance to providers and to develop and disseminate best practices and other information to support and accelerate adoption, implementation, and effective use of patient decision aids and shared decision making by providers.

"(B) OBJECTIVES.—The objective of a Center is to enhance and promote the adoption of patient decision aids and shared decision making through—

"(i) providing assistance to eligible providers with the implementation and effective use of, and training on, patient decision aids; and

"(ii) the dissemination of best practices and research on the implementation and effective use of patient decision aids.

"(3) SHARED DECISION-MAKING PARTICIPATION GRANTS.—

"(A) IN GENERAL.—The Secretary shall provide grants to health care providers for the development and implementation of shared decision making techniques and to assess the use of such techniques.

"(B) GUIDEBOOK.—In order to facilitate the use of best practices, the Secretary shall provide a guidebook to eligible grantees under this subsection on the use of patient decision aids.

"(4) FUNDING.—For purposes of carrying out this section there are authorized to be appropriated such sums as may be necessary for fiscal year 2010 and each subsequent fiscal year."

"SEC. 3902. PRESENTATION OF PRESCRIPTION DRUG BENEFIT AND RISK INFORMATION—SENATE S11719

"November 19, 2009 CONGRESSIONAL RECORD—SENATE
and risks of prescription drugs in a standard-
ized format (such as a table or drug facts box) to the promotional labeling or print adver-
sizing of such drugs would improve health care outcomes by clinicians and pa-
tients and consumers, then the Secretary, not later than 3 years after the date of sub-
mission of the report under subsection (c), shall review and, if appropriate, propose regula-
tions as necessary to implement such format.
(e) Clarification.—Nothing in this section shall be construed to restrict the existing authorities of the Secretary with respect to benefit and risk information.
SEC. 3508. DEMONSTRATION PROGRAM TO INTE-
GRATE AND IMPROVE PATIENT SAFETY TRAINING INTO
CLINICAL EDUCATION OF HEALTH PROFESSIONALS.
(a) In General.—The Secretary may award grants to eligible entities or consortia under this section to carry out demonstration projects to develop and implement academic curricula that integrates quality improve-
ment and patient safety in the clinical edu-
cation of health professionals. Such awards shall be made on a competitive basis and pursuant to peer review.
(b) Eligibility.—To be eligible to receive a grant under subsection (a), an entity or con-
sortium—
(1) submit to the Secretary an application at such time, in such manner, and con-
taining such information as the Secretary may require; 
(2) be or include— 
(A) a health professions school; 
(B) a school of public health; 
(C) a school of social work; 
(D) a school of nursing; 
(E) a school of pharmacy; 
(F) an institution with a graduate medical education program; 
(G) a school of health care administration; 
(3) collaborate in the development of cur-
ricula described in subsection (a) with an or-
ganization that accredits such school or in-
stitution; 
(4) provide for the collection of data re-
garding the effectiveness of the demonstra-
tion project; and 
(5) provide matching funds in accordance with subsection (c).
(c) Matching Funds.—
(1) In General.—The Secretary may make a grant to an entity or consortium under this section only if the entity or consortium agrees to make available non-Federal con-
tributions toward the costs of the program to be funded under the grant in an amount that is not less than $1 for each $5 of Federal funds provided under the grant.
(2) Determination of Amount Con-
tributed.—Non-Federal contributions under paragraph (1) may be in cash or in-kind, fair-
ly evaluated, including equipment or serv-
ces. Amounts provided by the Federal Gov-
ernment, or services assisted or subsidized to any significant extent by the Federal Gov-
ernment, may not be included in deter-
mining the amount of such contributions.
(d) Evaluation.—The Secretary shall take such action as may be necessary to evaluate the projects under this section; publish, make publicly available, and disseminate the results of such evaluations on a wide basis as is practicable.
(e) Termination.—Not later than 2 years after the date of enactment of this section, and annually thereafter, the Secretary shall sub-
mit to the Committee on Health, Education, Labor, and Pensions and the Com-
mmittee on Finance of the Senate and the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representa-
tives, pursuant to section 199A of title 5, United States Code:
(1) describes the specific projects supported under this section; and
(2) contains recommendations for Congress based on the evaluation conducted under subsection (d).
SEC. 3509. IMPROVING WOMEN’S HEALTH.
(a) Health and Human Services Office On Women’s Health;
(1) Establishment.—Part A of title II of the Public Health Service Act (42 U.S.C. 202 et seq.) is amended by adding at the end the following:
SEC. 229. Health and Human Services Office on Women’s Health.
(a) Establishment of Office.—There is established an Office on Women’s Health (re-
ferred to in this section as the ‘‘Office’’). The Office shall be headed by a Deputy Assistant Secretary for Women’s Health who may report to the Secretary.
(b) Duties.—The Secretary, acting through the Office, with respect to the health concerns of women, shall—
(1) establish short-range and long-range goals and objectives within the Department of Health and Human Services and, as rel-
evant and appropriate, coordinate with other appropriate offices on activities within the Department that relate to disease preven-
tion, health promotion, service delivery, re-
current healthcare, and training in profes-
sional education, for issues of particular con-
cern to women throughout their lifespan;
(2) provide expert advice and consultation to the Secretary concerning scientific, legal, ethical, and policy issues relating to wom-
en’s health;
(3) monitor the Department of Health and Human Services’ offices, agencies, and regional activities regarding women’s health and identify needs regarding the coordina-
tion of activities, including intramural and extramural multidisciplinary activities;
(4) establish a Department of Health and Human Services Coordinating Committee on Women’s Health, which shall be chaired by the Deputy Assistant Secretary for Women’s Health and composed of senior level rep-
resentatives from each of the agencies and offices of the Department of Health and Human Services;
(5) establish a National Women’s Health Information Center to—
(A) facilitate the exchange of information regarding matters relating to health infor-
mation, health promotion, preventive health services, research advances, and education in the appropriate offices;
(B) facilitate access to such information;
(C) assist in the analysis of issues and problems relating to the matters described in paragraph (4);
(D) provide technical assistance with re-
spect to the exchange of information (includ-
ing facilitating the development of materials for such technical assistance);
(E) coordinate efforts to promote women’s health programs and policies with the pri-
vate sector and others; and
(F) through publications and any other means appropriate, provide for the exchange of information of the Office and recipi-
ents of grants, contracts, and agreements under this section to the Office, and health professionals and the general pub-
lic.
(c) Grants and Contracts Regarding Duties.—
(1) Authority.—In carrying out subsection (b), the Secretary may make grants to, and enter into cooperative agreements, contracts, and other arrangements with, public and private entities, agencies, and or-
ganizations.
(2) Evaluation and Dissemination.—The Secretary shall—
(A) require the Office to enter into contracts with public and private entities, agencies, and organizations, provide for evaluations of projects carried out with financial assistance provided under paragraph (1) and for the dis-
semination of information developed as a re-
sult of such projects.
(b) Transfer of Functions.—There are transferred to the Office on Women’s Health (established under section 229 of the Public Health Service Act, as added by this sec-
tion), all functions exercised by the Office on Women’s Health of the Public Health Service prior to the date of enactment of this sec-
tion, including all personnel and compensa-
tion authority, all delegation and assign-
ment authority, and all remaining appro-
priations. All orders, determinations, rules, regulations, permits, awards, grants, contracts, certificates, licenses, registra-
tions, privileges, and other administrative actions that—
(A) have been issued, made, granted, or al-
lowed to become effective by the President, any Federal agency or official thereof, or by a court of competent jurisdiction, in the per-
formance of functions transferred under this paragraph; and
(B) are in effect at the time this section takes effect, or were final before the date of enactment of this section and are to become effective on or after such date,
shall continue in effect according to their terms until modified, terminated, super-
seeded, set aside, or revoked in accordance with law by the President, the Secretary, or other authorized official, a court of com-
petent jurisdiction, or by operation of law.
(c) Centers for Disease Control and Prevention Office of Women’s Health.—
Part A of title III of the Public Health Serv-
ice Act (42 U.S.C. 241 et seq.) is amended by adding at the end the following:
SEC. 310A. Centers for Disease Control and Prevention Office of Wom-
EN’S HEALTH.
(a) Establishment.—There is established within the Office of the Director of the Centers for Disease Control and Prevention, an office to be known as the Office of Women’s Health (referred to in this section as the ‘‘Of-
ifice’’). The Office shall be headed by a direc-
tor who shall be appointed by the Director of such Centers.
(b) Purpose.—The Director of the Office shall—
(1) report to the Director of the Centers for Disease Control and Prevention on the current level of the Centers’ activity regard-
ing women’s health conditions across, where appropriate, age, biological, and sociocultural contexts, in all aspects of the Centers’ work, including prevention pro-
grams, public and professional education, services, and treatment;
(2) establish short-range and long-range goals and objectives within the Centers for women’s health and, as relevant and appro-
priate, coordinate with other appropriate offices on activities within the Centers that re-
late to disease prevention, research and training, service delivery, and policy devel-

dopment, for issues of particular concern to women;
(3) identify projects in women’s health that should be conducted or supported by the Centers;
(a) ESTABLISHMENT.—There is established within the Office of the Director, an Office of Women's Health and Gender-Based Research (referred to in this section as the 'Office'). The Office shall be headed by a director who shall be appointed by the Administrator of the Office of Women's Health established under section 229(b)(4).

(b) PURPOSE.—The Office shall:

(1) report to the Administrator on the current Administration level of activity regarding women's health in the jurisdiction of the Administration, including, where relevant and appropriate, adequate inclusion of women and analysis of data by sex in accordance with needs that are identified; and

(2) establish short and long range goals and objectives within the Administration concerning women's health within the jurisdiction of the Administration (referred to in this section as the 'Administration') levels of activity regarding women's participation in clinical trials and the analysis of data by sex in the testing of drugs, medical devices, and biological products across, where appropriate, age, biological, and sociocultural contexts; and

(3) provide information to women and health care providers on areas in which differences between men and women exist.

(c) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2010 through 2014.

(d) OFFICE.—Nothing in this subsection shall be construed to preclude the Secretary from establishing within the Substance Abuse and Mental Health Administration an Office of Women's Health.

(e) AGENCY FOR HEALTHCARE RESEARCH AND QUALITY ACTIVITIES REGARDING WOMEN'S HEALTH.—Section 501(f) of the Public Health Service Act (42 U.S.C. 290aa(f)) is amended—

(1) by redesignating sections 925 and 926 as sections 925 and 926 respectively; and

(2) by inserting after section 924 the following:

SEC. 913. OFFICE OF WOMEN'S HEALTH.

(a) ESTABLISHMENT.—The Secretary shall establish within the Office of the Administrator of the Health Resources and Services Administration, an office to be known as the Office of Women's Health. The Office shall be headed by a director who shall be appointed by the Administrator.

(b) PURPOSE.—The Director of the Office shall:

(1) report to the Administrator on the current Administration level of activity regarding women's health across, where appropriate, age, biological, and sociocultural contexts;

(2) establish short range and long range goals and objectives within the Health Resources and Services Administration regarding women's health and, as relevant and appropriate, coordinate with other appropriate offices on activities within the Administration that relate to guidelines, training, health service delivery, research, and demonstration projects, for issues of particular concern to women;

(3) identify projects in women's health that should be conducted or supported by the Office;

(4) consult with health professionals, non-governmental organizations, consumer organizations, women's health professionals and, other individuals and groups, as appropriate, on Agency policy with regard to women; and

(5) serve as a member of the Department of Health and Human Services Coordinating Committee on Women's Health (established under section 229(b)(4)) of the Public Health Service Act.

(c) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2010 through 2014.

(1) by redesignating sections 925 and 926 as sections 925 and 926 respectively; and

(2) by inserting after section 924 the following:

SEC. 925. ACTIVITIES REGARDING WOMEN'S HEALTH.

(a) ESTABLISHMENT.—There is established within the Office of the Director, an Office of Women's Health and Gender-Based Research (referred to in this section as the 'Office').

(b) PURPOSE.—The official designated under subsection (a) shall:

(1) report to the Director on the current Agency level of activity regarding women's health, across, where appropriate, age, biological, and sociocultural contexts; in all aspects of Agency work, including the development of evidence reports and clinical practice protocols and the conduct of research into patient outcomes; delivery of health care services, quality of care, and access to health care; and

(2) establish short-range and long-range goals and objectives within the Agency that relate to health services and medical effectiveness research, for issues of particular concern to women; and

(3) develop and implement an Office of Women's Health program for women who are lesbian, gay, bisexual, or transgendered.

(c) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2010 through 2014.

(1) by redesignating sections 290aa(f) as paragraphs (5) and (6), respectively; and

(2) by inserting after section 290aa(f) the following:

SEC. 926. PATIENT NAVIGATOR PROGRAM.

(a) ESTABLISHMENT.—There is established within the Office of the Commissioner of Food and Drug Administration an office to be known as the Office of Women's Health (referred to in this section as the 'Office'). The Office shall be headed by a director who shall be appointed by the Commissioner of Food and Drugs.

(b) PURPOSE.—The Office shall:

(1) report to the Commissioner of Food and Drugs on current Food and Drug Administration (referred to in this section as the 'Administration') levels of activity regarding women's participation in clinical trials and the analysis of data by sex in the testing of drugs, medical devices, and biological products across, where appropriate, age, biological, and sociocultural contexts; and

(2) establish short-range and long-range goals and objectives within the Administration concerning women's participation in clinical trials and the analysis of data by sex in the testing of drugs, medical devices, and biological products across, where appropriate, age, biological, and sociocultural contexts; and

(3) provide information to women and health care providers on areas in which differences between men and women exist.

(c) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2010 through 2014.

(1) by redesignating sections 290aa(f) as paragraphs (5) and (6), respectively; and

(2) by inserting after section 290aa(f) the following:

SEC. 3510. PATIENT NAVIGATOR PROGRAM.
(1) by striking subsection (d)(3) and inserting the following:

"(3) LIMITATIONS ON GRANT PERIOD.—In carrying out this section, the Secretary shall ensure that the total period of a grant does not exceed 4 years;";

(2) in subsection (e), by adding at the end the following:

"(3) MINIMUM CORE PROFICIENCIES.—The Secretary shall not award a grant to an entity under this section unless such entity provides assurances that patient navigators recruited, assigned, trained, or employed using grant funds meet minimum core proficiencies, as defined by the entity that submits the application, that are tailored for the maintenance and implementation of the navigator involved;"; and

(3) in subsection (m)—

(A) in paragraph (1), by striking "and $5,500,000 for fiscal year 2012;" and inserting "$3,500,000 for fiscal year 2010, and such sums as may be necessary for each of fiscal years 2011 through 2015;"; and

(B) in paragraph (2), by striking "2010" and inserting "2015."

SEC. 3511. AUTHORIZATION OF APPROPRIATIONS. Except where otherwise provided in this subtitle, any amendment made by this Title—

(A) in paragraph (1), by striking "and $5,500,000 for fiscal year 2012;" and inserting "$3,500,000 for fiscal year 2010, and such sums as may be necessary for each of fiscal years 2011 through 2015;"; and

(B) in paragraph (2), by striking "2010" and inserting "2015."

TITLE IV—PREVENTION OF CHRONIC DISEASE AND IMPROVING PUBLIC HEALTH

Subtitle A—Modernizing Disease Prevention and Public Health Systems

SEC. 4001. NATIONAL PREVENTION, HEALTH PROMOTION AND PUBLIC HEALTH COUNCIL

(a) ESTABLISHMENT.—The President shall establish, within the Department of Health and Human Services, a council to be known as the "National Prevention, Health Promotion and Public Health Council" (hereafter referred to in this section as the "Council")—

(1) to develop and oversee the implementation of a national health strategy, and shall review and revise such strategy periodically. Such strategy shall—

(i) set specific goals and objectives for improving the health of the United States through federally-supported prevention, health promotion, and public health programs, consistent with ongoing goal setting efforts conducted by specific agencies;

(ii) establish specific and measurable actions and timelines to carry out the strategy, and determine accountability for meeting those timelines, within and across Federal departments and agencies; and

(iii) make recommendations to improve Federal efforts related to prevention, health promotion, public health, and integrative health care. Such recommendations shall incorporate the most effective and achievable means of improving the health status of Americans and reducing the incidence of preventable illness and disability in the United States;

(b) REPORT.—Not later than July 1, 2010, and annually thereafter through January 1, 2015, the Council shall submit to the President and the relevant committees of Congress a report that—

(1) describes the activities and efforts on prevention, health promotion, and public health and activities to develop a national strategy conducted by the Council during the period for which the report is prepared;

(2) describes the national progress in meeting specific prevention, health promotion, and public health goals defined in the strategy and further describes corrective actions recommended by the Council and taken by relevant agencies and organizations to meet those goals;

(3) contains a list of national priorities on health promotion and disease prevention to address lifestyle behavior modification (smoking cessation, proper nutrition, appropriate exercise, mental health, behavioral health, substance use disorder, and domestic violence screenings) and the prevention measures for the 5 leading disease killers in the United States;

(4) contains specific science-based initiatives to achieve the measurable goals of Healthy People 2010; and

(5) contains specific plans for consolidating Federal health programs and Centers that exist to promote healthy behavior and reduce disease risk (including eliminating programs and offices determined to be, or projects, ineffective in meeting the priority goals of Healthy People 2010);

(c) FUNDING.—There are hereby authorized to be transferred to the states, the District of Columbia, and the territories, for the purposes of the Council for the years 2010 through 2015 the sums of (I) $3,500,000 for fiscal year 2010, and such sums as may be necessary for each of fiscal years 2011 through 2015, and (II) $3,500,000 for fiscal year 2010, and such sums as may be necessary for each of fiscal years 2011 through 2015.

(d) USE OF FUND.—The Secretary of Health and Human Services shall—

(1) for fiscal year 2010, $500,000,000;

(2) for fiscal year 2011, $750,000,000;

(3) for fiscal year 2012, $1,000,000,000;

(4) for fiscal year 2013, $1,250,000,000;

(5) for fiscal year 2014, $1,500,000,000; and

(6) for fiscal year 2015, and each fiscal year thereafter, $2,000,000,000.

(e) REPORT.—Not later than July 1, 2010, and annually thereafter through January 1, 2015, the Council shall submit to the President and the relevant committees of Congress a report that—

(1) describes the activities and efforts on prevention, health promotion, and public health and activities to develop a national strategy conducted by the Council during the period for which the report is prepared;

(2) describes the national progress in meeting specific prevention, health promotion, and public health goals defined in the strategy and further describes corrective actions recommended by the Council and taken by relevant agencies and organizations to meet those goals;

(3) contains a list of national priorities on health promotion and disease prevention to address lifestyle behavior modification (smoking cessation, proper nutrition, appropriate exercise, mental health, behavioral health, substance use disorder, and domestic violence screenings) and the prevention measures for the 5 leading disease killers in the United States;

(4) contains specific science-based initiatives to achieve the measurable goals of Healthy People 2010; and

(5) contains specific plans for consolidating Federal health programs and Centers that exist to promote healthy behavior and reduce disease risk (including eliminating programs and offices determined to be, or projects, ineffective in meeting the priority goals of Healthy People 2010);

(6) contains specific plans to ensure that all Federal health care programs are fully coordinated with science-based prevention recommendations by the Director of the Centers for Disease Control and Prevention; and

(7) includes specific plans 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 paragraph (4).

(f) PERIODIC REVIEWS.—(1) The Secretary and the Comptroller General of the United States shall jointly conduct periodic reviews, not less than every 5 years, and evaluations of every Federal disease prevention and health promotion initiative implemented by the Council. Such reviews shall be evaluated based on effectiveness in meeting metrics-based goals with an analysis posted on such agencies’ public Internet website.

SEC. 4002. PREVENTION AND PUBLIC HEALTH FUND

(a) PURPOSE.—It is the purpose of this section to establish a Prevention and Public Health Fund (referred to in this section as the "Fund"), to be administered through the Department of Health and Human Services, Office of the Secretary, to provide for expanded and sustained national investment in prevention and public health programs to improve health and reduce disease and costs of growth in private and public sector health care costs.

(b) FUNDING.—There are hereby authorized to be appropriated, and appropriated, to the Fund, out of any monies in the Treasury not otherwise appropriated—

(1) for fiscal year 2010, $500,000,000; and

(2) for fiscal year 2011, $750,000,000.

(c) USE OF FUND.—(1) The Secretary shall transfer amounts in the Fund to the Department of Health and Human Services to increase funding, over the fiscal year beginning on October 1, 2010, such amounts as determined necessary to carry out such programs and activities as determined by the Secretary.
year 2008 level, for programs authorized by the Public Health Service Act, for prevention, wellness, and public health activities including prevention research and health screening, such as the Community Prevention Services Act, as amended by Public Law 110–374; 122 Stat. 4051, the National Institutes of Health, the Centers for Disease Control and Prevention, the Institute of Medicine, specialty medical associations, patient groups, and scientific societies.

(2) Duties.—The duties of the Task Force shall include—

(a) the development of additional topic areas for new recommendations and interventions related to those topic areas, including those related to specific sub-populations and age groups;

(b) at least once during every 5-year period, review interventions and updates to recommendations related to existing topic areas, including new or improved techniques to assess the health effects of interventions;

(c) development of recommendations with Federal Government health objectives and related target setting for health improvement;

(d) the enhanced dissemination of recommendations;

(e) the provision of technical assistance to those health care professionals, agencies and organizations that request it for implementation of the Guide recommendations, and those organizations requesting it for implementation of the recommendations of the Task Force, ensuring adequate staff resources, and assistance to those organizations requesting it for implementation of the Guide recommendations;

(f) providing yearly reports to Congress and related agencies identifying gaps in research and the need for recommendations and recommendations related to those topic areas, including those related to specific populations and age groups; and

(2) ROLE OF AGENCY.—The Agency shall provide ongoing administrative, research, and technical support for the operations of the Task Force, including coordinating and supporting the dissemination of the recommendations of the Task Force, ensuring adequate staff resources, and assistance to those organizations requesting it for implementation of the Guide recommendations.

(3) COORDINATION WITH COMMUNITY PREVENTIVE SERVICES TASK FORCE.—The Task Force shall take appropriate steps to coordinate its work with the U.S. Preventive Services Task Force and the Advisory Committee on Immunization Practices, and any recommendations made by such task forces for the purpose of developing recommendations, to be published in the Guide to Clinical Preventive Services (referred to in this section as the ‘Guide’), for individuals and organizations delivering clinical services, including primary care professionals, health care systems, professional societies, employers, community organizations, non-profit organizations, other policy-makers, governmental public health agencies, health care quality organizations, and organizations developing national health objectives. Such recommendations shall be consistent with clinical preventive best practice recommendations from the Agency for Healthcare Research and Quality, the National Institutes of Health, the Centers for Disease Control and Prevention, the Institute of Medicine, specialty medical associations, patient groups, and scientific societies.

(a) Establishment and Purpose.—The Director of the Centers for Disease Control and Prevention shall convene an independent Community Preventive Services Task Force (referred to in this section as the ‘Task Force’) to be composed of individuals with appropriate expertise. Such Task Force shall review the scientific evidence related to the effectiveness, appropriateness, and cost-effectiveness of clinical preventive services for the purpose of developing recommendations for the health care community, and updating previous recommendations, to be published in the Guide to Clinical Preventive Services (referred to in this section as the ‘Guide’), for individuals and organizations delivering clinical services, including primary care professionals, health care systems, professional societies, employers, community organizations, non-profit organizations, other policy-makers, governmental public health agencies, health care quality organizations, and organizations developing national health objectives. Such recommendations shall be consistent with clinical preventive best practice recommendations from the Agency for Healthcare Research and Quality, the National Institutes of Health, the Centers for Disease Control and Prevention, the Institute of Medicine, specialty medical associations, patient groups, and scientific societies.

(b) Duties.—The duties of the Task Force shall include—

(A) the development of additional topic areas for new recommendations and interventions related to those topic areas, including those related to specific sub-populations and age groups;

(B) at least once during every 5-year period, review interventions and updates to recommendations related to existing topic areas, including new or improved techniques to assess the health effects of interventions;

(C) the development of recommendations with Federal Government health objectives and related target setting for health improvement;

(D) the enhanced dissemination of recommendations;

(E) the provision of technical assistance to those health care professionals, agencies and organizations that request it for implementation of the Guide recommendations, and those organizations requesting it for implementation of the recommendations of the Task Force, ensuring adequate staff resources, and assistance to those organizations requesting it for implementation of the Guide recommendations; and

(F) providing yearly reports to Congress and related agencies identifying gaps in research and the need for recommendations and recommendations related to those topic areas, including those related to specific populations and age groups; and

(2) ROLE OF AGENCY.—The Agency shall provide ongoing administrative, research, and technical support for the operations of the Task Force, including coordinating and supporting the dissemination of the recommendations of the Task Force, ensuring adequate staff resources, and assistance to those organizations requesting it for implementation of the Guide recommendations; and

(3) COORDINATION WITH COMMUNITY PREVENTIVE SERVICES TASK FORCE.—The Task Force shall take appropriate steps to coordinate its work with the U.S. Preventive Services Task Force and the Advisory Committee on Immunization Practices, including the examination of how each task force’s recommendations interact at the nexus of clinical and community.

(4) OPERATION.—Operation. In carrying out the duties under paragraphs (2) and (3), the Task Force is subject to the provisions of Appendix 2 of title 5, United States Code.

(5) AUTHORIZATION OF APPROPRIATIONS.—This title shall be authorized by such sums as may be necessary for each fiscal year to carry out the activities of the Task Force.

(a) Establishment and Purpose.—The Coordinator of the Centers for Disease Control and Prevention shall establish a Community Preventive Services Task Force (referred to in this section as the ‘Task Force’) to be composed of individuals with appropriate expertise. Such Task Force shall review the scientific evidence related to the effectiveness, appropriateness, and cost-effectiveness of clinical preventive services for the purpose of developing recommendations for the health care community, and updating previous recommendations, to be published in the Guide to Community Preventive Services (referred to in this section as the ‘Guide’), for individuals and organizations delivering population-based services, including primary care professionals, health care systems, professional societies, employers, community organizations, non-profit organizations, schools, governmental public health agencies, Indian tribes, tribal organizations and urban Indian organizations, medical groups, Congress and other policy-makers. Congress—

(A) the submission of yearly reports to Congress and related agencies identifying gaps in research, such as preventive services that receive an insufficient evidence statement, and recommending priority areas that deserve further examination, including areas related to populations and age groups not adequately addressed by current recommendations;

(B) providing ongoing administrative, research, and technical support for the operations of the Task Force, including coordinating and supporting the dissemination of the recommendations of the Task Force, ensuring adequate staff resources, and assistance to those organizations requesting it for implementation of the Guide recommendations; and

(C) ROLE OF AGENCY.—The Secretary shall consult with the Institute of Medicine, specialty medical associations, patient groups, and scientific societies.

(2) TECHNICAL AMENDMENTS.—

(A) Section 399U of the Public Health Service Act (as added by section 2 of the ALS Diagnosed Conditions Awareness Act (Public Law 110–373; 122 Stat. 4047)) is redesignated as section 399S.

(B) Section 399R of such Act (as added by section 2 of the Prenatally and Postnatally Diagnosed Conditions Awareness Act (Public Law 110–374; 122 Stat. 4651)) is redesignated as section 399T.

SEC. 4004. EDUCATION AND OUTREACH CAMPAIGN REGARDING PREVENTIVE BENEFITS.

(a) In General.—The Secretary of Health and Human Services (referred to in this section as the ‘Secretary’) shall provide for the planning and implementation of a national public–private partnership for a prevention and health promotion education and outreach campaign to raise public awareness of health improvement across the life span. Such campaign shall include the dissemination of information that—

(1) describes the importance of utilizing preventive services to promote wellness, reduce health disparities, and mitigate chronic disease;

(2) promotes the use of preventive services recommended by the United States Preventive Services Task Force and the Community Preventive Services Task Force;

(3) encourages healthy behaviors linked to the prevention of chronic diseases;

(4) explains the preventive services covered under health plans offered through a Gateway;

(5) describes additional preventive care supported by the Centers for Disease Control and Prevention, the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration, the Agency for Healthcare Research and Quality, the National Institutes of Health, the Centers for Disease Control and Prevention, the Institute of Medicine, specialty medical associations, patient groups, and scientific societies;

(6) includes general health promotion information;

(b) CONSULTATION.—In coordinating the campaign under subsection (a), the Secretary shall consult with the Institute of Medicine, specialty medical associations, patient groups, and scientific societies.

(2) TECHNICAL AMENDMENTS.—

(A) Section 399U of the Public Health Service Act (as added by section 2 of the ALS Diagnosed Conditions Awareness Act (Public Law 110–373; 122 Stat. 4047)) is redesignated as section 399S.

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(1) describes the importance of utilizing preventive services to promote wellness, reduce health disparities, and mitigate chronic disease;

(2) promotes the use of preventive services recommended by the United States Preventive Services Task Force and the Community Preventive Services Task Force;

(3) encourages healthy behaviors linked to the prevention of chronic diseases;

(4) explains the preventive services covered under health plans offered through a Gateway;

(5) describes additional preventive care supported by the Centers for Disease Control and Prevention, the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration, the Agency for Healthcare Research and Quality, the National Institutes of Health, the Centers for Disease Control and Prevention, the Institute of Medicine, specialty medical associations, patient groups, and scientific societies;

(6) includes general health promotion information;

(b) CONSULTATION.—In coordinating the campaign under subsection (a), the Secretary shall consult with the Institute of Medicine, specialty medical associations, patient groups, and scientific societies.
media campaign.—

(1) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish and implement a national science-based media campaign on health promotion and disease prevention.

(2) UNIVERSITY CAMPAIGN.—The campaign implemented under paragraph (1)—

(A) shall be designed to address proper nutrition, regular exercise, smoking cessation, obesity prevention, and the 5 leading disease killers in the United States, and secondary prevention through disease screening programs;

(B) shall be carried out through competitively bid contracts awarded to entities providing for the professional production and design of such campaign;

(C) may include the use of television, radio, Internet, and other commercial marketing venues and may be targeted to specific age groups based on peer-reviewed social research;

(D) shall not be duplicative of any other Federal efforts relating to health promotion and disease prevention;

(E) may include the use of humor and nationally recognized positive role models.

(3) EVALUATION.—The Secretary shall ensure that the campaign implemented under paragraph (1) is subject to an independent evaluation every 2 years and shall report every 2 years to Congress on the effectiveness of such campaigns towards meeting science-based metrics.

(d) 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 to health care providers regarding preventive and obesity-related services that are available to Medicaid enrollees, including obesity screening and counseling for children and adults.

(e) INFORMATION TO ENROLLEES.—Each State shall design a public awareness campaign to educate Medicaid enrollees regarding availability and coverage of such services, with the goal of reducing incidences of obesity.

(3) REPORT.—Not later than January 1, 2011, and every 3 years thereafter through January 1, 2017, the Secretary of Health and Human Services shall report to Congress on the status and effectiveness of efforts under paragraphs (1) and (2), including summaries of the States and coverage of awareness of obesity-related services.

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

Subtitle B—Increasing Access to Clinical Preventive Services

SEC. 4101. SCHOOL-BASED HEALTH CENTERS.

(a) GRANTS FOR THE ESTABLISHMENT OF SCHOOL-BASED HEALTH CENTERS.—

(1) IN GENERAL.—The Secretary shall establish a program to award grants to eligible entities to establish—

(A) grants for the establishment of school-based health centers;

(B) grants for the establishment of school-based health centers serving special populations; or

(C) comprehensive primary health services at school-based health centers.

(2) ELIGIBILITY.—To be eligible for a grant under this subsection, an entity shall—

(A) be a school-based health center or a sponsoring facility of a school-based health center; and

(B) have the capacity to provide comprehensive, primary, and preventive care and health services to children and adolescents who are residents of an area designated as medically underserved.

(3) PREFERENCES.—In awarding grants under this section, the Secretary shall give preference to—

(A) entities that ensure the provision of services to—

(i) low-income children and adolescents;

(ii) children with special needs; and

(iii) individuals living in medically underserved areas;

(B) entities that provide services in medically underserved areas or a health professional shortage area;

(C) entities that provide services in medically underserved areas or a health professional shortage area or serve medically underserved children and adolescents;

(D) entities that provide services in medically underserved areas or a health professional shortage area and have experience in providing services in medically underserved areas or a health professional shortage area;

(E) entities that provide services in medically underserved areas or a health professional shortage area and have experience in providing services in medically underserved areas or a health professional shortage area and have experience in providing services in medically underserved areas or a health professional shortage area;

(F) entities that provide services in medically underserved areas or a health professional shortage area and have experience in providing services in medically underserved areas or a health professional shortage area;

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(aaa) entities that provide services in medically underserved areas or a health professional shortage area and have experience in providing services in medically underserv
(B) evidence of local need for the services to be provided by the SBHC; and

(c) an assurance that—

(i) SBHC services will be provided to those health care providers for whom parental or guardian consent has been obtained in cooperation with Federal, State, and local laws governing health care service provision to children and adolescents;

(ii) the SBHC has made and will continue to make every reasonable effort to establish and maintain collaborative relationships with other health care providers in the catchment area of the SBHC;

(iii) the SBHC will provide on-site access during the academic day when school is in session and 24-hour coverage through an on-call system and its backup health providers to ensure access to services on a year-round basis when the school or the SBHC is closed;

(iv) the SBHC will be integrated into the school environment and will coordinate health services with school personnel, such as administrators, teachers, nurses, counselors, and support personnel, as well as with other community providers located at the school;

(v) the SBHC sponsoring facility assumes all responsibility for the SBHC administration, operations, and oversight; and

(vi) the SBHC will comply with Federal, State, and local laws concerning patient privacy and student records, including regulations promulgated under the Health Insurance Portability and Accountability Act of 1996 and section 444 of the General Education Provisions Act; and

(d) such other information as the Secretary may require.

(2) The Secretary may give preference to applicants who demonstrate an ability to serve students who:

(A) Communities that have evidenced barriers to primary health care and mental health and substance use disorder prevention services for children and adolescents.

(B) Communities with high per capita numbers of children and adolescents who are uninsured, underinsured, or enrolled in publicly funded health care programs.

(C) Populations of children and adolescents that have historically demonstrated difficulty in accessing health and mental health and substance use disorder prevention services.

(3) Limitations.—

(A) in general.—Any provider of services that is determined by a State to be in violation of a State law described in subsection (a)(3)(B) with respect to activities carried out at a SBHC is closed; and

(B) no overlapping grant period.—No entity that has received funding under section 330 for a grant period shall be eligible for a grant under this section for with respect to the same grant period.

(g) Matching Requirement.—

(1) in general.—Each eligible entity that receives a grant under this grant shall provide, from non-Federal sources, an amount equal to 20 percent of the amount of the grant (with the provision provided in case CEPA or CEPA-in-kind) to carry out the activities supported by the grant.

(2) Waiver.—The Secretary may waive all or part of the matching requirement described in paragraph (1) for any fiscal year that applying the matching requirement to the SBHC would result in serious hardship or an inability to carry out the purposes of this section.

(h) Supplement, Not Supplant.—Grant funds provided under this section shall be used to supplement, not supplant, other Federal or State funds.

(i) Evaluation.—The Secretary shall develop and implement a plan for evaluating SBHCs and monitoring quality performance under the awards made under this section.

(j) Age Appropriate Services.—An eligible entity receiving funds under this section shall only provide age appropriate services through a SBHC funded under this section to an individual.

(k) Parental Consent.—An eligible entity receiving funds under this section shall not provide services through a SBHC funded under this section to an individual without the consent of the parent or guardian of such individual if such consent is considered a minor under applicable State law.

(l) Authorization of Appropriations.—

For purposes of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2010 through 2014.

SEC. 4102. ORAL HEALTHCARE PREVENTION ACT.

(a) in general.—Title III of the Public Health Service Act (42 U.S.C. 241 et seq.), as amended by section 3025, is amended by adding at the end of the following:

"PART T—ORAL HEALTHCARE PREVENTION ACT."

SEC. 399LL-1. RESEARCH-BASED DENTAL CURES DISEASE MANAGEMENT.

(2) upon a showing of good cause, waive the application of all or part of the requirements prescribed in this section as the 'campaign') that is funded in cooperation with Federal, State, and local laws governing health care service provision to children and adolescents;

(2) in general.—The Secretary may award grants which may be used to pay the costs associated with expanding and modernizing existing buildings for use as an SBHC, including the purchase of prefabricated buildings to install on the school property.

(3) Limitations.—

(A) In General.—Any provider of services that is determined by a State to be in violation of a State law described in subsection (a)(3)(B) with respect to activities carried out at a SBHC is closed; and

(ii) the SBHC sponsoring facility assumes all responsibility for the SBHC administration, operations, and oversight;

(iii) the SBHC will provide on-site access during the academic day when school is in session and 24-hour coverage through an on-call system and its backup health providers to ensure access to services on a year-round basis when the school or the SBHC is closed;

(iv) the SBHC will be integrated into the school environment and will coordinate health services with school personnel, such as administrators, teachers, nurses, counselors, and support personnel, as well as with other community providers located at the school;

(v) the SBHC sponsoring facility assumes all responsibility for the SBHC administration, operations, and oversight; and

(vi) the SBHC will comply with Federal, State, and local laws concerning patient privacy and student records, including regulations promulgated under the Health Insurance Portability and Accountability Act of 1996 and section 444 of the General Education Provisions Act; and

(D) NO OVERLAPPING GRANT PERIOD. —No entity that has received funding under section 330 for a grant period shall be eligible for a grant under this section for with respect to the same grant period.

(G) MATCHING REQUIREMENT.—

(1) IN GENERAL.—Each eligible entity that receives a grant under this section shall provide, from non-Federal sources, an amount equal to 20 percent of the amount of the grant (with the provision provided in case CEPA or CEPA-in-kind) to carry out the activities supported by the grant.

(2) WAIVER.—The Secretary may waive all or part of the matching requirement described in paragraph (1) for any fiscal year that applying the matching requirement to the SBHC would result in serious hardship or an inability to carry out the purposes of this section.

(H) SUPPLEMENT, NOT SUPPLANT.—Grant funds provided under this section shall be used to supplement, not supplant, other Federal or State funds.

(I) EVALUATION.—The Secretary shall develop and implement a plan for evaluating SBHCs and monitoring quality performance under the awards made under this section.

(J) AGE APPROPRIATE SERVICES.—An eligible entity receiving funds under this section shall only provide age appropriate services through a SBHC funded under this section to an individual.

(K) PARENTAL CONSENT.—An eligible entity receiving funds under this section shall not provide services through a SBHC funded under this section to an individual without the consent of the parent or guardian of such individual if such consent is considered a minor under applicable State law.

(L) AUTHORIZATION OF APPROPRIATIONS.—

For purposes of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2010 through 2014.

SEC. 4102. ORAL HEALTHCARE PREVENTION ACT.

(a) in general.—Title III of the Public Health Service Act (42 U.S.C. 241 et seq.), as amended by section 3025, is amended by adding at the end of the following:

"PART T—ORAL HEALTHCARE PREVENTION ACT."

SEC. 399LL-1. RESEARCH-BASED DENTAL CURES DISEASE MANAGEMENT.

(1) FUNDS.—Funds awarded under a grant under this section are used to supplement, not supplant, other Federal or State funds.

(2) USE OF FUNDS.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall award demonstration grants to eligible entities to demonstrate the effectiveness of research-based dental caries disease management activities.

(b) ELIGIBILITY.—To be eligible for a grant under this section, an entity—

(i) be a community-based provider of dental services (as defined by the Secretary), including a Federally-qualified health center, a clinic, an area health education center, a hospital, a health center, a tribe, a tribe or tribal organization, or an urban Indian organization (as such terms are defined in section 4 of the Indian Health Care Improvement Act); or a subrecipient of a grant made under section 330(b) from a State or local health agency to provide dental services, medical, dental, public health, nursing, nutrition educational institutions, or national organizations involved in improving children's oral health; and

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

(c) USE OF FUNDS.—A grantee shall use amounts received under a grant under this section to demonstrate the effectiveness of research-based dental caries disease management activities.

(d) USE OF INFORMATION.—The Secretary shall utilize information generated from grantees under this section in planning and implementing the public education campaign under section 330L.

SEC. 399LL-2. AUTHORIZATION OF APPROPRIATIONS.

There is authorized to be appropriated to carry out this part, such sums as may be necessary.

(b) SCHOOL-FOUNDED SEALANT PROGRAMS.—SEC. 317M(1)(b) of the Public Health Service Act (42 U.S.C. 247b-14(c)(1)) is amended by striking “may award grants to States and Indian tribes” and inserting “shall award a grant to each of the 50 States and territories and to Indian tribes, Indian organizations and urban Indian organizations (as such terms are defined in section 4 of the Indian Health Care Improvement Act)”.

(c) ORAL HEALTH INFRASTRUCTURE.—SEC. 317M of the Public Health Service Act (42 U.S.C. 247b-14) is amended—

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

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

"(Q) ORAL HEALTH INFRASTRUCTURE.—

(1) COOPERATIVE AGREEMENTS.—The Secretary, acting through the Director of the
 Centers for Disease Control and Prevention, shall enter into cooperative agreements with State, territorial, and Indian tribes or tribal organizations (as those terms are defined in section 407 of the Indian Health Care Improvement Act) to establish oral health leadership and program guidance, oral health data collection and interpretation, (including determining health among vulnerable populations), a multi-dimensional delivery system for oral health, and to implement science-based programs (including dental sealants and fluoride varnish) to improve oral health.

(2) AUTHORIZATION OF APPROPRIATIONS.—

There are appropriated to the Secretary, such sums as may be necessary to carry out this subsection for fiscal years 2010 through 2014.

(d) UPDATING NATIONAL ORAL HEALTH SURVEILLANCE SYSTEMS.—

(1) PRAMS.—

(A) IN GENERAL.—The Secretary of Health and Human Services (referred to in this subsection as the ‘‘Secretary’’) shall carry out activities to update and improve the Pregnancy Risk Assessment Monitoring System (referred to in this section as ‘‘PRAMS’’) as it relates to oral healthcare.

(B) STATE REPORTS AND MANDATORY MEASUREMENTS.—

(i) IN GENERAL.—Not later than 5 years after the date of enactment of this Act, and every 5 years thereafter, a State shall submit to the Secretary a report concerning activities conducted within the State under PRAMS.

(ii) MEASUREMENTS.—The oral healthcare measurements developed by the Secretary for use under PRAMS shall be mandatory in each State with respect to States for purposes of the State reports under clause (i).

(C) FUNDING.—There is authorized to be appropriated to carry out this paragraph, such sums as may be necessary.

(2) NATIONAL HEALTH AND NUTRITION EXAMINATION SURVEY.—The Secretary shall develop oral healthcare components that shall include tooth-level surveillance for inclusion in the National Health and Nutrition Examination Survey. Such components shall be updated by the Secretary at least every 6 years. For purposes of this paragraph, the term ‘‘tooth-level surveillance’’ means a clinical examination where an examiner looks for disease on a tooth surface, on enamel, or in the mouth and as expanded by the Division of Oral Health of the Centers for Disease Control and Prevention.

(3) MEDICAL EXPENDITURES PANEL SURVEY.—

The Secretary shall ensure that the Medical Expenditures Panel Survey by the Agency for Healthcare Research and Quality includes the verification of dental utilization, expenditure, and coverage findings through conduct of a look-back analysis.

(4) NATIONAL ORAL HEALTH SURVEILLANCE SYSTEMS.—

(A) APPROPRIATIONS.—There is authorized to be appropriated, such sums as may be necessary for each of fiscal years 2010 through 2014 for the participation of States in the National Oral Health Surveillance System from 16 States to all 50 States, territories, and District of Columbia.

(B) REPORT.—The Secretary shall ensure that the National Oral Health Surveillance System include the measurement of early childhood caries.


(a) Coverage of Personalized Prevention Plan Services.—

(1) IN GENERAL.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended—

(A) in subparagraph (DD), by striking ‘‘and’’ and at the end;

(B) in subparagraph (ER), by adding ‘‘and’’ at the end; and

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

‘‘(FF) personalized prevention plan services (as defined in subsection (hhh));’’.

(2) CONFORMING AMENDMENTS.—Clauses (i) and (ii) of section 1842(b)(2)(K) of the Social Security Act (42 U.S.C. 1395x(b)(2)(K)) are each amended by striking ‘‘subsection (ww)(1)’’ and inserting ‘‘subsections (ww)(1) and (hhh)’’.

(b) Personalized Prevention Plan Services Defined.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

‘‘Annual Wellness Visit.—(hhh)(1) The term ‘personalized prevention plan services’ means the creation of a plan for an individual—

(A) that includes a health risk assessment (that meets the guidelines established by the Secretary under paragraph (4)(A)) of the individual that is completed prior to or as part of the same visit with a health professional described in paragraph (3); and

(B) that—

(i) takes into account the results of the health risk assessment established under the paragraph (A) or (www)(1) of the Indian Health Care Improvement Act; and

(ii) may contain the elements described in paragraph (2).

(2) Subject to paragraph (4)(B), the elements described in this paragraph are the following:

(A) The establishment of, or an update to, the individual’s medical and family history.

(B) A list of current providers and suppliers that are regularly involved in providing medical care to the individual (including a list of all prescribed medications).

(C) A measurement of height, weight, body mass index (or waist circumference, if appropriate), blood pressure, and other routinely measured data.

(D) Detection of any cognitive impairment.

(E) The establishment of, or an update to, a screening schedule for the next 5 to 10 years, as appropriate, based on recommendations of the United States Preventive Services Task Force and the Advisory Committee on Immunization Practices, and the individual’s health status, screening history, and age-appropriate preventive services covered under paragraph (4)(B).

(3) Medical Examinations.—

(A) The Secretary shall develop and make available guidelines that describe medical examinations to be utilized by providers to meet the requirement under paragraph (A)(ii)(I). The Secretary may utilize such guidelines as part of the requirement to develop a personalized prevention plan to comply with this paragraph.

(B) The Secretary may coordinate with community-based entities (including State Health Insurance Programs, Area Agencies on Aging, Aging and Disability Resource Centers, and the Administration on Aging) to—

(i) ensure that health risk assessments are accessible to beneficiaries; and

(ii) provide appropriate support for the completion of health risk assessments by beneficiaries.

(C) The Secretary shall establish procedures to make beneficiaries and providers aware of the requirement that a beneficiary complete a health risk assessment prior to or at the same time as receiving personalized prevention plan services.

(D) To the extent practicable, the Secretary shall ensure that the use of, integration with, and coordination of health information technology (including use of electronic medical records and personal health records) and may experiment with the use of person-centered technology to aid in the development of and adherence to provider recommendations in order to improve the health status of beneficiaries.

(E) An entity that provides or arranges for the provision of covered services within the preceding 12-month period.
"(1) The Secretary shall establish procedures to make beneficiaries aware of the option to select an initial preventive physical examination or personalized prevention plan on a periodic basis, within 12 months following the date that a beneficiary’s coverage begins under part B, which shall include information regarding any relevant differences between the services that are described in section 1861(hhh)(1) and the services that are required to be provided under this subsection.

"(2)(EE)," by inserting "(2)(FF) (including administered prevention plan services; and (3) by adding at the end the following new paragraph:

"(d) The term ‘preventive services’ means the following:

(1) The screening and preventive services described in section 1861(hhh)(1) (other than the services described in subparagraph (M) of such subsection).

(2) An initial preventive physical examination (as defined in subsection (ww)).

(3) Personalized prevention plan services (as defined in subsection (hh)).

(b) Coinsurance.

(1) General application.

(A) In general. Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395a(a)), as amended by section 4103(c)(3), is amended—

(1) by striking "(13) other diagnostic, screening, preventive services described in section 1861(s)(10)(A)"; and

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

"(i) the Secretary may, if the Secretary determines appropriate, the Secretary may—

"(1) modify—

"(A) the coverage of any preventive service described in subparagraph (A) of paragraph (1) of section 1861(ddd)(3) to the extent that such modification is consistent with the recommendations of the United States Preventive Services Task Force; and

"(2) the services included in the initial preventive physical examination described in subparagraph (B) of such section; and

"(ii) by inserting before the semicolon at the end of the following: '", or preventive services described in subparagraph (A) of section 1861(ddd)(3) that are appropriate for the individual and are furnished by an outpatient department of a hospital, the amount determined under paragraph (1) after "(80 percent)"; and

(c) Waiver of application of deductible.

(1) Section 1833(t)(1)(B)(iv) of the Social Security Act (42 U.S.C. 1395t(b)(5)(B)(iv)), as amended by section 4103(a)(4), is amended—

(1) by striking "(2) provide that no payment shall be made for the removal of tissue or other matter or other procedure that is furnished in connection with, as a result of, and in the same clinical encounter as the screening test.";

"(e) Effective date. The amendments made by this section shall apply to items and services furnished on or after January 1, 2011.

SEC. 4106. IMPROVING ACCESS TO PREVENTIVE SERVICES IN MEDICARE.

(a) Authority to modify or eliminate coverage of certain preventive services.

Section 1891 of the Social Security Act (42 U.S.C. 1396m) is amended by adding at the end the following new subsection:

"(5) Authority to modify or eliminate coverage of certain preventive services. Notwithstanding any other provision of this title, effective beginning on January 1, 2010, if the Secretary determines appropriate, the Secretary may—

"(I) with respect to preventive services described in subparagraph (A) of paragraph (1) of section 1861(ddd)(3) that are appropriate for the individual and are furnished by an outpatient department of a hospital, the amount determined under paragraph (1) after "(80 percent)"; and

"(ii) in subparagraph (W), by striking "and" after the semicolon at the end;
"(B) with respect to an adult individual, approved vaccines recommended by the Advisory Committee on Immunization Practices (an advisory committee established by the Secretary through the Centers for Disease Control and Prevention) and their administration; and (C) any medical or remedial services (provided or recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law) that are necessary to reduce the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level;''.

(b) INCREASED FMAP.—Section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)), as amended by sections 2001(a)(3)(A) and 2004(c)(1), is amended in the first sentence—(1) by striking "", and (4)"" and inserting "", and (4);"" and (2) by inserting before the period the following: ";", and (5) in the case of a State that provides medical assistance for services and vaccines described in subparagraphs (A) and (B) of subsection (a)(15), and prohibits cost-sharing for such services and vaccines, the Federal medical assistance percentage, as determined under this subsection and subsection (y) (without regard to paragraph (1)(C) of such subsection), shall be increased by 1 percentage point with respect to medical assistance for such services and vaccines and for items and services described in subsection (a)(4))

(c) EFFECTIVE DATE.—The amendments made under this section shall take effect on January 1, 2013.

SEC. 4107. COVERAGE OF COMPREHENSIVE TOBACCO CESSATION SERVICES FOR PREGNANT WOMEN IN MEDICAID.

(a) REQUIRING COVERAGE OF COUNSELING AND PHARMACOTHERAPY FOR CESSATION OF TOBACCO USE BY PREGNANT WOMEN.—Section 1905 of the Social Security Act (42 U.S.C. 1396d), as amended by sections 2001(a)(3)(B) and 2003, is further amended—

(1) by striking "and" before "(C);"; and (2) by inserting before the semicolon at the end the following new subparagraph: "and (B) by counseling and pharmacotherapy for cessation of tobacco use by pregnant women (as defined in subsection (b)(2)(D)) after "complicate the pregnancy".

(b) APPLICATION TO ALTERNATIVE COST-SHARING.—Section 1916A(b)(3)(B)(iii) of such Act (42 U.S.C. 1396p-4), as amended by section 2001(a)(3)(A) and 2003, is further amended—

(1) by striking "", and (5)"" and inserting "", and (5);"" and (2) by inserting in the case of pregnant women when recommended in accordance with the Guideline referred to in section 1906(bb)(1) for the Food and Drug Administration under the over-the-counter monograph process for purposes of promoting, and when used to promote, tobacco cessation by pregnant women in accordance with the Guideline referred to in section 1906(bb)(2)(A) after "complicate the pregnancy".

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on October 1, 2010.

SEC. 4108. INCENTIVES FOR PREVENTION OF CHRONIC DISEASES IN MEDICAID.

(a) INITIATIVES.—

(1) ESTABLISHMENT.—(A) IN GENERAL.—The Secretary shall award grants to States to carry out initiatives to provide incentives to Medicaid beneficiaries for cessation of tobacco use by pregnant women who use tobacco products or who are being treated for tobacco use that is—(A) by or under the supervision of a physician; or (B) by any other health care professional who—(1) is legally authorized to furnish such services under State law (or the State regulatory mechanism provided by State law) of the State in which the services are furnished; and (2) is authorized to receive payment for other services under this title or is designated by the Secretary for this purpose.

(2) Subject to paragraph (3), such term is limited to—(A) services recommended with respect to pregnant women in ‘Treating Tobacco Use and Dependence: 2008 Update‘; (B) services recommended by the National Registry of Evidence-Based Programs and Practices for Health Service in May 2008, or any subsequent modification of such Guideline; and 

(b) EFFORTS OF AN INSTITUTION OR ENTITY.—The Secretary shall award grants to States to carry out initiatives that encourage behavior modification and determine intervention strategies that are uniquely suited to address the needs of Medicaid beneficiaries and that have demonstrated success in helping individuals achieve one or more of the following:—(i) Quitting the use of tobacco products, (ii) Reducing or preventing their weight, (iii) Lowering their cholesterol.

(2) FLEXIBILITY IN IMPLEMENTATION.—A State may enter into arrangements with public or private partnerships, public-private partnerships, Indian tribes, or similar entities or organizations to carry out programs described in paragraph (1).

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on October 1, 2010.
(1) IN GENERAL.—The Secretary of Health and Human Services shall submit to the Director of the Centers for Disease Control and Prevention a final report on the program, including the results of the independent assessment required under paragraph (2). The plan shall include an intermediate evaluation of the effectiveness of the initiatives carried out with grants awarded under this section and a recommendation regarding whether funding for expanding or extending the initiatives should be extended beyond January 1, 2016.

(2) COMMUNITY TRANSFORMATION PLAN.—(A) IN GENERAL.—An eligible entity that receives a grant under this section shall submit to the Director (for approval) a detailed plan that includes the policy, environmental, programmatic, and as appropriate infrastructural changes needed to promote healthy living and reduce health disparities. (B) ACTIVITIES.—An eligible entity shall use funds received under a grant under this section to carry out programs described in this section to conduct activities to measure changes in the prevalence of chronic disease risk factors among community members participating in preventive health activities.

(3) DISSEMINATION.—A grantee under this section shall—

(C) IN-KIND SUPPORT.—An eligible entity may provide in-kind support such as staff, equipment, or office space in carrying out activities under this section.

(D) ADMINISTRATIVE COSTS INCURRED BY ELIGIBLE ENTITIES.—An eligible entity shall use amounts received under a grant under this section to conduct activities to measure changes in the prevalence of chronic disease risk factors among community members participating in preventive health activities.

(4) EVALUATION.—(A) IN GENERAL.—An eligible entity shall use amounts received under a grant under this section to conduct activities to measure changes in the prevalence of chronic disease risk factors among community members participating in preventive health activities.

(B) TYPES OF MEASURES.—In carrying out subparagraph (A), the eligible entity shall, with respect to residents in the community, measure—

(i) changes in weight;
(ii) changes in physical activity;
(iii) changes in tobacco use prevalence;
(iv) changes in emotional well-being and overall mental health;
(v) other factors using community-specific data from the Behavioral Risk Factor Surveillance System; and
(vi) other factors as determined by the Secretary.

(C) REPORTING.—An eligible entity shall annually submit to the Director a report containing an evaluation of activities carried out under the grant.

(5) TRAINING.—(A) IN GENERAL.—The Director shall develop a program to provide training for eligible entities on effective strategies for the prevention and control of chronic disease and the link between physical, emotional, and social well-being.

(B) COMMUNITY TRANSFORMATION PLAN.—The Director shall provide appropriate feedback and technical assistance to grantees to establish community transformation plans.

(6) PROHIBITION.—A grantee shall not use funds provided under a grant under this section to create video games or to carry out any other activities that may lead to higher rates of obesity or related diseases.

(7) AUTHORIZATION OF APPROPRIATIONS.—There are appropriated for the 5-year period beginning on January 1, 2011, $100,000,000 to the Secretary for the development of community transformation plans.

SEC. 4202. COMMUNITY TRANSFORMATION PROGRAMS FOR MEDICARE BENEFICIARIES.

(a) HEALTHY LIVING FOR MEDICARE BENEFICIARIES.—(1) IN GENERAL.—The Secretary of Health and Human Services shall submit to the Director of the Centers for Disease Control and Prevention an annual report on the implementation, evaluation, and dissemination of evidence-based community prevention activities in order to reduce chronic disease rates, prevent the development of secondary conditions, address health disparities, and develop a stronger evidence-base of effective prevention programming.

(b) ELIGIBILITY.—To be eligible to receive a grant under subsection (a), an entity shall—

(1) be—

(A) a State governmental agency; (B) a local governmental agency; (C) a national network of community-based organizations; (D) a State or local non-profit organization; or
(E) an Indian tribe; and
(2) submit to the Director an application at such time, in such a manner, and containing such information as the Director may require, including a description of the program to be carried out under the grant.

(c) USE OF FUNDS.—An eligible entity shall—

(1) USE OF FUNDS.—An eligible entity shall use amounts received under a grant under this section to carry out programs described in this section.

(2) REPORTING.—An eligible entity shall—

(A) submit to the Secretary annual reports to the Director an application at such time, in such a manner, and containing such information as the Director may require, including a description of the program to be carried out under the grant.

(b) ELIGIBILITY.—An eligible entity shall be—

(1) an Indian tribe; and
(2) submit to the Director a final report on the program that includes—

(A) a description of the program to be carried out under the grant; and
(B) recommendations for such legislation and appropriations.

(3) ELIGIBILITY.—To be eligible to receive a grant under this section, an entity shall—

(1) be—

(A) a State governmental agency; (B) a local governmental agency; (C) a national network of community-based organizations; (D) a State or local non-profit organization; or
(E) an Indian tribe; and
(2) submit to the Director an application at such time, in such a manner, and containing such information as the Director may require, including a description of the program to be carried out under the grant.

(c) USE OF FUNDS.—An eligible entity shall use amounts received under a grant under this section to carry out programs described in this section.

(d) REPORTING.—An eligible entity shall annually submit to the Director a report containing an evaluation of activities carried out under the grant.

(e) TRAINING.—(1) IN GENERAL.—The Director shall develop a program to provide training for eligible entities on effective strategies for the prevention and control of chronic disease and the link between physical, emotional, and social well-being.

(2) COMMUNITY TRANSFORMATION PLAN.—The Director shall provide appropriate feedback and technical assistance to grantees to establish community transformation plans.

(3) EVALUATION.—The Director shall pro-vide a literature review and framework for the evaluation of programs conducted as part of the grant program under this section, in addition to working with academic institutions or other entities with expertise in outcome evaluation.

(f) PROHIBITION.—A grantee shall not use funds provided under a grant under this section to—

(1) create video games or to carry out any other activities that may lead to higher rates of obesity or related diseases.

(g) AUTHORIZATION OF APPROPRIATIONS.—There are appropriated for the 5-year period beginning on January 1, 2011, $100,000,000 to the Secretary for the development of community transformation plans.
provide public health community interventions, screenings, and where necessary, clinical referrals for individuals who are between 55 and 64 years of age.

(2) Grantees be eligible to receive a grant under paragraph (1), an entity shall—

(A) be—

(i) a State health department;

(ii) a local health department; or

(iii) an Indian tribe;

(B) 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 program to be carried out under the grant;

(C) develop the capacity, if funded, to develop the relationships necessary with relevant health agencies, health care providers, community-based organizations, and insurers to carry out the activities described in paragraph (3), such relationships to include the identification of a community-based clinical partner, such as a community health center or rural health clinic.

(3) USE OF FUNDS.—

(A) IN GENERAL.—A State or local health department shall use amounts received under such a grant under this subsection to carry out a program to provide the services described in this paragraph to individuals who are between 55 and 64 years of age.

(B) PUBLIC INTERVENTIONS.—

(i) IN GENERAL.—In developing and implementing such activities, a grantee shall collaborate with the Centers for Disease Control and Prevention and the Administration on Aging, and relevant local agencies and organizations.

(ii) TYPES OF INTERVENTION ACTIVITIES.—Intervention activities conducted under this subparagraph may include efforts to improve nutrition, increase physical activity, reduce tobacco use and substance abuse, improve mental health, and promote healthy lifestyles among the target population.

(C) COMMUNITY PREVENTIVE SCREENINGS.—

(i) IN GENERAL.—In addition to community-wide public health interventions, a State or local health department shall use amounts received under a grant under this subsection to conduct community-based public health interventions; and

(ii) MONITORING.—Grantees under this section shall maintain records of screening and follow-up services to measure changes in the prevalence of chronic disease risk factors among individuals monitored for the purpose.

(4) PILOT PROGRAM EVALUATION.—The Secretary shall conduct an annual evaluation of the effectiveness of programs under this subsection. In determining such effectiveness, the Secretary shall consider changes in the prevalence of uncontrolled chronic disease risk factors among new Medicare enrollees (or individuals nearing enrollment, including those who are 63 and 64 years of age) who reside in States or localities receiving grants under this section as compared with national and historical data for those States and localities for the same population.

(5) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection, such sums as may be necessary for each of fiscal years 2010 through 2014.

(6) ADMINISTRATION.—Chapter 33 of title 42, United States Code shall not apply to the exercise of the authorities under the provisions of this subsection.
rooms, hospitals, and other medical settings. The standards shall ensure that such equipment is accessible to, and usable by, individuals with accessibility needs, and shall allow independent entry to, use of, and exit from the equipment by such individuals to the maximum extent possible.

(b) Medical Diagnostic Equipment Coverage.—Section 156 of the Americans with Disabilities Act of 1990 (42 U.S.C. 12102) is amended—

(1) in subsection (a), by striking “medical diagnostic” and inserting “medical diagnostic or therapeutic”;

(2) in subsection (c), by striking “at such time, in consultation with local authorities."

(c) Review and Amendment.—The Architectural and Transportation Barriers Compliance Board, in consultation with the Commissioner of the Food and Drug Administration, shall periodically review and, as appropriate, amend the standards in accordance with the Administrative Procedure Act (2 U.S.C. 551 et seq.)."

SEC. 4204. IMMUNIZATIONS.

(a) State Authority to Purchase Recommended Vaccines for Adults.—Section 317 of the Public Health Service Act (42 U.S.C. 247b) is amended—

(1) by striking “IMMUNIZATION COVERAGE.—Section 317 of the Public Health Service Act (42 U.S.C. 247b) is amended by adding at the end the following:—

(’’(1) IMMUNIZATION COVERAGE.—The Secretary may negotiate and enter into contracts with manufacturers of vaccines for the purchase and delivery of vaccines for adults as provided for under subsection (e).’’;

(2) in subsection (e), by striking “IMMUNIZATION COVERAGE.—The Secretary may negotiate and enter into contracts with manufacturers of vaccines for the purchase and delivery of vaccines for adults as provided for under subsection (e).’’;

(b) Demonstration Program to Improve Immunization Coverage.—Section 317 of the Public Health Service Act (42 U.S.C. 247b), as amended by subsection (a), is further amended by adding at the end the following:

(’’(a) Demonstration Program to Improve Immunization Coverage.—Section 317 of the Public Health Service Act (42 U.S.C. 247b), as amended by subsection (a), is further amended by adding at the end the following:—

(1) in paragraph (1), by striking “for each of the fiscal years 1998 through 2005’’; and

(2) in paragraph (2), by striking “after October 1, 1997’’.

(c) Reauthorization of Immunization Program.—Section 317(b) of the Public Health Service Act (42 U.S.C. 247b) is amended—

(1) in paragraph (1), by striking “for each of the fiscal years 1998 through 2005’’; and

(2) in paragraph (2), by striking “after October 1, 1997’’.

(d) Rule of Construction Regarding Access to Immunizations.—Nothing in this section (including the amendments made by this section), or any other provision of this Act (including any amendments made by this Act) shall be construed to create rights of action in any State or political subdivision thereof.

(e) GAO Study and Report on Medicare Beneficiary Access to Vaccines.—(1) study.—The Comptroller General of the United States (in this section referred to as the ‘‘Comptroller General’’) shall conduct a study on the ability of Medicare beneficiaries to access routinely recommended vaccines covered under the prescription drug program under part D of title XVIII of the Social Security Act for immunizations, or incentives for immunization; and

(2) report.—The Comptroller General shall submit to the Secretary an evaluation of the effectiveness of the demonstration program established under this subsection to carry out this subsection, such sums as may be necessary for each of fiscal years 2010 through 2014.’’;

SEC. 4205. NUTRITION LABELING OF STANDARD MENU ITEMS AT CHAIN RESTAURANTS.

(a) Technical Amendments.—Section 403(q)(5)(A) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 343(q)(5)(A)) is amended—

(1) in subitem (i), by inserting at the beginning —

“(a) except as provided in clause (H)(III)’’;

and

(2) in subitem (ii), by inserting at the beginning —

“(b) except as provided in clause (H)(III)’’.

(b) Labeling Requirements.—Section 403(q)(5)(A) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 343(q)(5)(A)) is amended by adding at the end the following:

“(H) RESTAURANTS, RETAIL FOOD ESTABLISHMENTS, AND VENDING MACHINES.—

(1) General Requirements for Restaurants and Similar Retail Food Establishments.—Except for food described in subclause (vii), in the case of food that is a standard menu item, the restaurant shall disclose the information described in subclauses (i) and (ii).

(2) Information Required to be Disclosed by Restaurants and Retail Food Establishments.—Except for food described in subclause (vii), the restaurant shall disclose the information described in subclause (i).”;

(c) Nondiscrimination.—The standards issued under this subsection shall apply to independent food establishments that is part of a chain with 20 or more locations doing business under the same name (regardless of the type of ownership of the locations) and offering for sale substantially the same menu items, the restaurant or similar retail food establishment shall disclose the information described in subclauses (i) and (ii)."
enable the public to understand, in the context of a total daily diet, the significance of the nutrition information that is provided on the menu board:

(1) In general.—An authorized official of any restaurant or similar retail food establishment and to the consumer upon request, the nutrition information required under clauses (C) and (D) of subparagraph (1); and

(2) to apply to any State or local requirement respecting a statement in the labeling of food that provides for a warning concerning the safety of the food or component of the food; or

(3) except as provided in section 408(q)(5)(H)(i) of the Federal Food, Drug, and Cosmetic Act (as added by subsection (b)), to apply to any restaurant or similar retail food establishment other than a restaurant or similar retail food establishment described in section 408(q)(5)(H)(i) of such Act.

SEC. 4206. DEMONSTRATION PROJECT CONCERNING INDIVIDUALIZED WELLNESS PLANS.

Section 330 of the Public Health Service Act (42 U.S.C. 241b) is amended by adding at the end the following:

`(a) DEMONSTRATION PROGRAM FOR INDIVIDUALIZED WELLNESS PLANS.—

(1) IN GENERAL.—The Secretary shall establish a pilot program to test the impact of providing at-risk populations who utilize community health centers funded under this section an individualized wellness plan that is designed to reduce risk factors for preventable conditions as identified by a comprehensive risk-factor assessment.

(2) AGREEMENTS.—The Secretary shall enter into an agreement with not more than 10 community health centers funded under this section to conduct activities under the pilot program under paragraph (1).

(b) WELLNESS PLANS.—

(A) IN GENERAL.—An individualized wellness plan prepared under the pilot program under this subsection may include one or more of the following as appropriate to the individual's identified risk factors:

(i) Nutritional counseling.

(ii) A physical activity plan.

(iii) Alcohol and smoking cessation counseling and services.

(iv) Stress management.

(v) Dietary supplements that have health claims approved by the Secretary.

(vi) Compliance assistance provided by a community health center employee.

(B) RISK FACTORS.—Wellness plan risk factors shall include—

(1) weight;

(2) tobacco and alcohol use;

(3) exercise rates;

(4) sleep;

(5) body mass index status; and

(6) blood pressure.

(C) COMPARISONS.—Individualized wellness plans shall make comparisons between the individual's wellness plan and a control group of individuals with respect to the risk factors described in subparagraph (B).

(d) AUTHORIZATION OF APPROPRIATIONS.—The Secretary is authorized to carry out this subsection, such sums as may be necessary.''

SEC. 4207. REASONABLE BREAK TIME FOR NURSING MOTHERS.

Section 7 of the Fair Labor Standards Act of 1938 (29 U.S.C. 207) is amended by adding at the end the following:

`(d) An employer shall provide—

(A) a reasonable break time for an employee to express breast milk for nursing child for 1 year after the child's birth each time such employee has need to express the milk; and

(B) a place, other than a bathroom, that is shielded from view and free from intrusion from coworkers and the public, which may be used by an employee to express breast milk.'
SEC. 3010. DATA COLLECTION, ANALYSIS, AND QUALITY.

(a) DATA COLLECTION.—

(1) IN GENERAL.—The Secretary shall ensure that, by not later than 2 years after the date of enactment of this title, any federally funded program or activity, including comparing community-based public health interventions in terms of effectiveness and cost;

(2) analyzing the translation of interventions from academic settings to real world settings; and

(3) developing effective strategies for organizing, financing, or delivering public health services in real world community settings, including comparing State and local health department structures and systems in terms of effectiveness and cost.

(b) EXISTING PARTNERSHIPS.—Research supported under this section shall be coordinated with the Community Preventive Services Task Force and carried out by building on existing partnerships within the Federal Government while also considering initiatives at the State and local levels in the private sector.

(c) ANNUAL REPORT.—The Secretary shall, on an annual basis, submit to Congress a report concerning the activities and findings with respect to research supported under this section.

(d) UNIFORM CATEGORIES AND COLLECTION REQUIREMENTS.—The Public Health Service Act (42 U.S.C. 201 et seq.) is amended by adding at the end the following:

"TITLE XXXI—DATA COLLECTION, ANALYSIS, AND QUALITY

SEC. 3101. DATA COLLECTION, ANALYSIS, AND QUALITY.

(a) DATA COLLECTION.—

(1) IN GENERAL.—The Secretary shall ensure that, by not later than 2 years after the date of enactment of this title, any federally funded program or activity, including comparing community-based public health interventions in terms of effectiveness and cost;

(2) analyzing the translation of interventions from academic settings to real world settings; and

(3) developing effective strategies for organizing, financing, or delivering public health services in real world community settings, including comparing State and local health department structures and systems in terms of effectiveness and cost.

(b) EXISTING PARTNERSHIPS.—Research supported under this section shall be coordinated with the Community Preventive Services Task Force and carried out by building on existing partnerships within the Federal Government while also considering initiatives at the State and local levels in the private sector.

(c) ANNUAL REPORT.—The Secretary shall, on an annual basis, submit to Congress a report concerning the activities and findings with respect to research supported under this section.

(d) UNIFORM CATEGORIES AND COLLECTION REQUIREMENTS.—The Public Health Service Act (42 U.S.C. 201 et seq.) is amended by adding at the end the following:

"TITLE XXXI—DATA COLLECTION, ANALYSIS, AND QUALITY

SEC. 3101. DATA COLLECTION, ANALYSIS, AND QUALITY.

(a) DATA COLLECTION.—

(1) IN GENERAL.—The Secretary shall ensure that, by not later than 2 years after the date of enactment of this title, any federally funded program or activity, including comparing community-based public health interventions in terms of effectiveness and cost;

(2) analyzing the translation of interventions from academic settings to real world settings; and

(3) developing effective strategies for organizing, financing, or delivering public health services in real world community settings, including comparing State and local health department structures and systems in terms of effectiveness and cost.

(b) EXISTING PARTNERSHIPS.—Research supported under this section shall be coordinated with the Community Preventive Services Task Force and carried out by building on existing partnerships within the Federal Government while also considering initiatives at the State and local levels in the private sector.

(c) ANNUAL REPORT.—The Secretary shall, on an annual basis, submit to Congress a report concerning the activities and findings with respect to research supported under this section.

(d) UNIFORM CATEGORIES AND COLLECTION REQUIREMENTS.—The Public Health Service Act (42 U.S.C. 201 et seq.) is amended by adding at the end the following:

"TITLE XXXI—DATA COLLECTION, ANALYSIS, AND QUALITY

SEC. 3101. DATA COLLECTION, ANALYSIS, AND QUALITY.

(a) DATA COLLECTION.—

(1) IN GENERAL.—The Secretary shall ensure that, by not later than 2 years after the date of enactment of this title, any federally funded program or activity, including comparing community-based public health interventions in terms of effectiveness and cost;

(2) analyzing the translation of interventions from academic settings to real world settings; and

(3) developing effective strategies for organizing, financing, or delivering public health services in real world community settings, including comparing State and local health department structures and systems in terms of effectiveness and cost.

(b) EXISTING PARTNERSHIPS.—Research supported under this section shall be coordinated with the Community Preventive Services Task Force and carried out by building on existing partnerships within the Federal Government while also considering initiatives at the State and local levels in the private sector.

(c) ANNUAL REPORT.—The Secretary shall, on an annual basis, submit to Congress a report concerning the activities and findings with respect to research supported under this section.

(d) UNIFORM CATEGORIES AND COLLECTION REQUIREMENTS.—The Public Health Service Act (42 U.S.C. 201 et seq.) is amended by adding at the end the following:

"TITLE XXXI—DATA COLLECTION, ANALYSIS, AND QUALITY

SEC. 3101. DATA COLLECTION, ANALYSIS, AND QUALITY.

(a) DATA COLLECTION.—

(1) IN GENERAL.—The Secretary shall ensure that, by not later than 2 years after the date of enactment of this title, any federally funded program or activity, including comparing community-based public health interventions in terms of effectiveness and cost;

(2) analyzing the translation of interventions from academic settings to real world settings; and

(3) developing effective strategies for organizing, financing, or delivering public health services in real world community settings, including comparing State and local health department structures and systems in terms of effectiveness and cost.
(7) provide employers (including small, medium, and large employers, as determined by the Director) with technical assistance, consultation, tools, and other resources in evaluating such employers’ employer-based wellness programs, including—

(‘‘A) measuring the participation and methods to increase participation of employees in such programs;

(B) developing standardized measures that assess policy, environmental and systems changes necessary to have a positive health impact on employees’ health behaviors, health outcomes, and health care expenditures; and

(C) evaluating such programs as they relate to changes in the health status of employees, the productivity of employees, the rate of workplace injury, and the medical costs incurred by employees; and

(2) build evaluation capacity among workplace staff by training employers on how to evaluate employer-based wellness programs by ensuring evaluation resources, technical assistance, and consultation are available to workplace staff as needed through such mechanisms as web portals, call centers, or other means.

SEC. 399MM–1. NATIONAL WORKSITE HEALTH COUNCIL.

(a) IN GENERAL.—In order to assess, analyze, and monitor over time data about workplace policies and programs, and to develop instruments to assess and evaluate comprehensive workplace chronic disease prevention and health promotion programs, policies and practices, the Council shall submit to Congress a report that includes the recommendations of the Director for the implementation of effective employer-based health care policies and programs.

(b) REPORT.—Upon the completion of each study under this section, the Council shall submit to Congress a report that includes recommendations for improving the identification of health care disparities for beneficiaries under this title and under title XXI, and

(1) include recommendations on the most effective strategies and approaches to reporting HEDIS quality measures as required under section 332(r)(3) and other nationally recognized quality performance measures, as appropriate, on such bases;

(2) REPORTS ON DATA ANALYSES.—Not later than 2 years after the date of the enactment of this section, and 4 years thereafter, the Secretary shall submit to Congress a report that includes recommendations for improving the identification of health care disparities for beneficiaries under this title and under title XXI that are based on analyses of the data collected under subsection (c).

(3) IMPLEMENTING EFFECTIVE APPROACHES.—Not later than 24 months after the date of enactment of this section, the Secretary shall implement the approaches identified in the report submitted under subsection (b)(1) for the ongoing, accurate, and timely collection and evaluation of data on health care disparities on the basis of race, ethnicity, sex, primary language, and disability status.

Title III of the Public Health Service Act (42 U.S.C. 231 et seq.), by section 3102, is further amended by adding at the end the following:

‘‘PART U—EMPLOYER-BASED WELLNESS PROGRAMS

SEC. 399ML. TECHNICAL ASSISTANCE FOR EMPLOYER-BASED WELLNESS PROGRAMS.

In order to expand the utilization of evidence-based promotion approaches in the workplace, the Director shall—

(1) provide employers (including small, medium, and large employers, as determined by the Director) with technical assistance, consultation, tools, and other resources in evaluating such employers’ employer-based wellness programs, including—

(A) measuring the participation and methods to increase participation of employees in such programs;

(B) developing standardized measures that assess policy, environmental and systems changes necessary to have a positive health impact on employees’ health behaviors, health outcomes, and health care expenditures; and

(C) evaluating such programs as they relate to changes in the health status of employees, the productivity of employees, the rate of workplace injury, and the medical costs incurred by employees; and

(2) build evaluation capacity among workplace staff by training employers on how to evaluate employer-based wellness programs by ensuring evaluation resources, technical assistance, and consultation are available to workplace staff as needed through such mechanisms as web portals, call centers, or other means.

SEC. 399MM–2. PRIORITIZATION OF EVALUATION BY SECRETARY.

The Secretary shall evaluate, in accordance with the programs funded through the Centers for Disease Control and Prevention before conducting such an evaluation of privately funded programs unless an entity with a privately funded wellness program requests such an evaluation.

SEC. 399MM–3. PROHIBITION OF FEDERAL WORKPLACE WELLNESS REQUIREMENTS.

Notwithstanding any other provision of this part, any recommendations, data, or assessments carried out under this part shall not be used to mandate requirements for workplace wellness programs.

Title XXIII of the Public Health Service Act (42 U.S.C. 300h et seq.) is amended by adding at the end the following:

SEC. 4304. EPIDEMIOLOGY-LABORATORY CAPACIT Y GRANTS.

(a) IN GENERAL.—Subject to the availability of appropriations, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish an Epidemiology and Laboratory Capacity Grant Program to award grants to State health departments as well as local health departments and tribal jurisdictions that meet such criteria as the Director determines appropriate. Academic centers that assist State and eligible local and tribal health departments may be eligible for funding under this section as the Director determines appropriate. Grants shall be awarded under this section to assist public health agencies in expanding surveillance for, and response to, infectious diseases and other conditions of public health importance by—

(1) strengthening epidemiologic capacity to identify and monitor the occurrence of infectious diseases and other conditions of public health importance;

(2) developing and maintaining an information exchange using national guidelines and complying with capacities and functions determined by an advisory council established and appointed by the Director; and

(3) developing and implementing prevention and control strategies.

(b) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $190,000,000 for each of fiscal years 2010 through 2013, of which—

(1) not less than $95,000,000 shall be made available each such fiscal year for activities under paragraphs (1) and (4) of subsection (a);

(2) not less than $60,000,000 shall be made available each such fiscal year for activities under subsection (a)(3); and

(3) not less than $32,000,000 shall be made available each such fiscal year for activities under subsection (a)(2).

SEC. 4305. ADVANCE RESEARCH AND TREAT-MENT FOR PAIN CARE MANAGEMENT.

(a) INSTITUTE OF MEDICINE CONFERENCE ON PAIN.—

(1) CONVENING.—Not later than 1 year after funding for appropriations made pursuant to this section, the Secretary of Health and Human Services shall seek to enter into an agreement with the Institute of Medicine of the National Academies to convene a Conference on Pain (in this subsection referred to as “the Conference”).

(2) PURPOSES.—The purposes of the Conference shall be to—

(A) increase the recognition of pain as a significant public health problem in the United States;

(B) evaluate the adequacy of assessment, diagnosis, treatment, and management of acute and chronic pain in the general population, and in identified racial, ethnic, gender, age, and other demographic groups that may be disproportionately affected by inequities in the assessment, diagnosis, treatment, and management of pain;

(C) identify barriers to appropriate pain care;

(D) establish an agenda for action in both the public and private sectors that will reduce barriers and improve the state of pain care research, education, and clinical care in the United States.

(3) OTHER APPROPRIATE ENTITY.—If the Institute of Medicine determines that it cannot, or fails to enter into an agreement under paragraph (1), the Secretary of Health and Human Services may...
enter into such agreement with another appropriate entity.

(4) REPORT.—A report summarizing the Conference’s findings and recommendations shall be submitted to the Congress not later than June 30, 2011.

(5) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this sub-section, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2010 and 2011.

(b) PAIN RESEARCH AT NATIONAL INSTITUTES OF HEALTH.—Section 502 of title IV of the Public Health Service Act (42 U.S.C. 294 et seq.) is amended by adding at the end the following:

**SEC. 409J. PAIN RESEARCH.**

(a) RESEARCH INITIATIVES.—

(1) IN GENERAL.—The Director of NIH is encouraged to continue and expand, through the Pain Consortium, an aggressive program of basic and clinical research on the causes of and potential treatments for pain.

(2) ANNUAL RECOMMENDATIONS.—Not less than annually, the Pain Consortium, in consultation with the Division of Program Coordination, Planning, and Strategic Initiatives, shall develop and submit to the Director of NIH recommendations on appropriate pain research initiatives that could be undertaken to facilitate the Pain Consortium or otherwise available for such initiatives.

(3)Appropriations.—In this subsection, the term ‘Pain Consortium’ means the Pain Consortium of the National Institutes of Health or a similar trans-National Institutes of Health coordinating entity designated by the Secretary for purposes of this subsection.

(b) INTRAGENCY PAIN RESEARCH COORDINATING COMMITTEE.—

(1) Establishment.—The Secretary shall establish not later than 1 year after the date of enactment of this section and as necessary maintain a committee, to be known as the Intragency Pain Research Coordinating Committee (in this section referred to as the ‘Committee’), to coordinate all efforts within the Department of Health and Human Services and other Federal agencies that relate to pain research.

(2) MEMBERSHIP.—

(A) IN GENERAL.—The Committee shall be composed of voting members appointed by the Secretary from among scientists, physicians, and other health professionals.

(B) ADDITIONAL MEMBERS.—The Committee shall also include non-voting members appointed by the Secretary as follows:

(i) 6 non-Federal members shall be appointed from among scientists, physicians, and other health professionals; and

(ii) 12 additional voting members appointed under subparagraph (B).

(c) TERMINATION.—The Committee shall terminate not later than 2 years after the date of enactment of this section.

(d) PAIN CARE DEFINED.—For purposes of this section, the term ‘pain care’ means the comprehensive care of patients with pain-related conditions.

(e) AUTHORIZATION OF APPROPRIATIONS.—There shall be appropriated to carry out this section, such sums as may be necessary for each of the fiscal years 2010 through 2012. Amounts appropriated under subsection (a) in any fiscal year shall be available for such initiatives for the period of fiscal years 2010 through 2012.

SEC. 4306. FUNDING FOR CHILDHOOD OBESITY PREVENTION AND TREATMENT.

To determine whether existing Federal health and wellness initiatives are effective in achieving their stated goals, the Secretary of Health and Human Services shall—

(1) conduct an evaluation of such programs as they relate to changes in health status of the American public and specifically on the health status of the Federal workforce, including absenteeism of employees, the productivity of employees, the rate of workplace injury; and the medical costs incurred by employees, and health conditions, including obesity, diabetes, and heart disease, as well as the costs of health insurance, as recognized by the Secretary of Health and Human Services.

(2) determine Health care initiatives have proven successful or not successful and what factors contributed to such conclusions.

**TITLE V—HEALTH CARE WORKFORCE**

Subtitle A—Purpose and Definitions

SEC. 5001. PURPOSE.

The purpose of this title is to improve access to and the delivery of health care services for all individuals, particularly low income, underserved, uninsured, minority, health disparity, and rural populations by—

(1) gathering and assessing comprehensive data in order for the health care workforce to meet the health care needs of individuals, including research on the supply, demand, distribution, diversity, and skills needs of the health care workforce; and

(2) increasing the supply of a qualified health care workforce to improve access to and the delivery of health care services for all individuals.

(3) enhancing health care workforce education and training to improve access to and the delivery of health care services for all individuals.

(4) providing support to the existing health care workforce to improve access to and the delivery of health care services for all individuals.

SEC. 5002. DEFINITIONS.

(a) This Title.—In this title:

(1) ALLED HEALTH PROFESSIONAL.—The term ‘allied health professional’ means an allied health professional as defined in section 798(b)(3) of the Public Health Service Act (42 U.S.C. 265p(5)) who—

(A) graduated and received an allied health professions degree or certificate from an institution of higher education; and

(B) is employed with a Federal, State, local, or tribal public health agency, in a setting where patients might require health care services, including acute care facilities, ambulatory care facilities, personal residences, and other settings of care located in health professional shortage areas, medically underserved areas, or medically underserved populations, as recognized by the Secretary of Health and Human Services.

(2) HEALTH CARE CAREER PATHWAY.—The term ‘healthcare career pathway’ means a
rigorous, engaging, and high quality set of courses and services that—
(A) includes an articulated sequence of academic and career courses, including 21st century skills,
(B) is aligned with the needs of healthcare industries in a region or State;
(C) prepares students for entry into the full range of postsecondary education options, including registered apprenticeships, and careers;
(D) provides academic and career counseling in student-to-counselor ratios that allow students to make informed decisions about academic and career options;
(E) meets academic standards. State requirements for secondary school graduation and is aligned with requirements for entry into postsecondary education, and applied workforces; and
(F) leads to 2 or more credentials, including—
(i) a secondary school diploma; and
(ii) a postsecondary degree, an apprenticeship or other occupational certification, a certificate, or a license.
(3) INSTITUTION OF HIGHER EDUCATION.—The term ‘institution of higher education’ means the meaning given the term in sections 101 and 102 of the Higher Education Act of 1965 (29 U.S.C. 1001 and 1002).
(4) LOCAL INDIVIDUAL, STATE WORKFORCE INVESTMENT BOARD, AND LOCAL WORKFORCE INVESTMENT BOARD.—
(A) LOCAL INDIVIDUAL.—The term ‘low-income individual’ has the meaning given that term in section 101 of the Workforce Investment Act of 1998 (29 U.S.C. 2801).
(B) STATE WORKFORCE INVESTMENT BOARD; LOCAL WORKFORCE INVESTMENT BOARD.—The terms ‘State workforce investment board’ and ‘local workforce investment board’, refer to a State workforce investment board established under section 111 of the Workforce Investment Act of 1998 (29 U.S.C. 2821) and a local workforce investment board established under section 117 of such Act (29 U.S.C. 2832), respectively.
(5) POSTSECONDARY EDUCATION.—The term ‘postsecondary education’ means—
(A) a 2-year program of instruction, or not less than a 1-year program of instruction that is acceptable for credit toward an associate or a baccalaureate degree, offered by an accredited educational institution;
(B) a certificate or registered apprenticeship program at the postsecondary level that combines technical and theoretical training through structured on-the-job learning with related instruction (in a classroom or through distance learning) while an individual is employed, working under the direction of qualified personnel or a mentor, and earning incremental wage increases aligned to employment, resulting in the acquisition of a nationally recognized and portable certificate, under a plan approved by the Office of Apprenticeship or a State agency recognized by the Department of Labor.
(b) TITLE VII OF THE PUBLIC HEALTH SERVICE ACT.—Section 790B of the Public Health Service Act (42 U.S.C. 265p) is amended—
(1) by striking paragraph (3) and inserting the following:
‘‘(3) PHYSICIAN ASSISTANT EDUCATION PROGRAM.—The term ‘physician assistant education program’ means an educational program in a public or private institution in a State or the District of Columbia that—
(A) has as its objective the education of individuals who, upon completion of their studies in the program, be qualified to provide primary care medical services with the supervision of a physician; and
(B) is accredited by the Accreditation Review Commission on Education for the Physician Assistant.’’;
and
(2) by adding at the end the following:
‘‘(12) AREA HEALTH EDUCATION CENTER.—The term ‘area health education center’ means a public or nonprofit private organization that has a cooperative agreement or contract in effect with an entity that has registered in paragraph (1)(A) or (i) of section 751, satisfies the requirements in section 751(d)(1), and has as one of its principal functions the operation of such an area health education center. Appropriate organizations may include hospitals, health organizations with accredited primary care training programs, accredited physician assistant educational programs associated with a college or university, and universities or colleges not operating a school of medicine or osteopathic medicine.
‘‘(13) AREA HEALTH EDUCATION CENTER PROGRAM.—The term ‘area health education center program’ means cooperative program consisting of an award under subsection (a)(1) or (a)(2) of section 751 for the purpose of planning, developing, operating, and evaluating an area health education center program in one or more area health education centers, which carries out the required activities described in section 751(c), satisfies the program requirements in paragraph (1) as one of its principal functions identifying and implementing strategies and activities that address health care workforce needs in its service area, in coordination with the local workforce investment boards.
‘‘(14) CLINICAL SOCIAL WORKER.—The term ‘clinical social worker’ has the meaning given the term in section 1861(hh)(1) of the Social Security Act (42 U.S.C. 1395x(hh)(1)).
‘‘(15) CULTURAL COMPETENCY.—The term ‘cultural competency’ shall be defined by the Secretary in a manner consistent with section 1707(d)(3).
‘‘(16) DIRECT CARE WORKER.—The term ‘direct care worker’ has the meaning given that term in the 2010 Standard Occupational Classification of the Department of Labor for Home Health Aides [31-1011], Psychiatric Aides [31-1013], and Personal Care Aides [39-9021].
‘‘(17) FEDERALLY QUALIFIED HEALTH CENTER.—The term ‘federally qualified health center’ has the meaning given that term in section 1861(aa)(1) of the Social Security Act (42 U.S.C. 1395x(aa)(1)).
‘‘(18) FRONTIER HEALTH PROFESSIONAL SHORTAGE AREA.—The term ‘frontier health professional shortage area’ means an area—
(A) with a population density less than 6 persons per square mile within the service area; and
(B) with respect to which the distance or time for the population to access care is excessive.
‘‘(19) GRADUATE PSYCHOLOGY.—The term ‘graduate psychology’ means an accredited program in professional psychology.
‘‘(20) HEALTH DISPARITY POPULATION.—The term ‘health disparity population’ has the meaning given such term in section 903(d)(1).
‘‘(21) HEALTH LITERACY.—The term ‘health literacy’ means the degree to which an individual has the capacity to obtain, communicate, process, and understand health information and services in order to make appropriate health care decisions.
‘‘(22) MENTAL HEALTH SERVICE PROFESSIONAL.—The term ‘mental health service professional’ means an individual with a graduate degree from an accredited institution of higher education in psychiatry, psychology, school psychology, behavioral pediatrics, psychiatric nursing, social work, school social work, substance abuse disorder prevention and treatment, marriage and family counseling, school counseling, or professional counseling.
‘‘(23) ONE-STOP DELIVERY SYSTEM CENTER.—The term ‘one-stop delivery system center’ means a one-stop delivery system described in section 296(a)(6) of the Workforce Investment Act of 1998 (29 U.S.C. 2866(c)).
‘‘(24) PARAPROFESSIONAL CHILD AND ADOLESCENT MENTAL HEALTH WORKER.—The term ‘paraprofessional child and adolescent mental health worker’ means an individual who is not a mental or behavioral health professional, but who works at the first stage of contact with children and families who are seeking mental or behavioral health services, including substance abuse prevention and treatment services.
‘‘(25) RACIAL AND ETHNIC MINORITY GROUP; RACIAL AND ETHNIC MINORITY POPULATION.—The terms ‘racial and ethnic minority group’ and ‘racial and ethnic minority population’ have the meaning given the term ‘racial and ethnic minority group’ in section 1707.
‘‘(26) RURAL HEALTH CLINIC.—The term ‘rural health clinic’ has the meaning given that term in section 330G(aa)(1) of the Social Security Act (42 U.S.C. 1395x(aa)).’’.
(c) TITLE VIII OF THE PUBLIC HEALTH SERVICE ACT—Section 81(a), of the Public Health Service Act (42 U.S.C. 296) is amended—
(1) by striking “means a” and inserting “means an accredited” as defined in paragraph (b); and
(2) by striking the period at the end and inserting the following: “where graduates are—
(A) authorized to sit for the National Council Licensure Examination-Registered Nurse (NCLEX-RN); or
(B) licensed registered nurses who will receive a graduate or equivalent degree or training to become a registered nursing education nurse as defined by section 81(b);”;
and
(3) by adding at the end the following:
‘‘(16) ACCELERATED NURSING DEGREE PROGRAM.—The term ‘accelerated nursing degree program’ means a program of education in professional nursing offered by an accredited school of nursing in which an individual holding a bachelors degree in another discipline receives a BSN or MSN degree in an accelerated time frame as determined by the accredited school of nursing.
‘‘(17) BRIDGE OR DEGREE COMPLETION PROGRAM.—The term ‘bridge or degree completion program’ means a program of education in professional nursing offered by an accredited school of nursing, as defined in paragraph (2), that leads to a baccalaureate degree in nursing. Such programs may include, Registered Nurse (RN) to Bachelor’s of Science in Nursing (BSN) programs, RN to MSN (‘Master of Science in Nursing’) programs, or BSN to Doctoral programs.”.
Subtitle B—Innovations in the Health Care Workforce

SEC. 5101. NATIONAL HEALTH CARE WORKFORCE COMMISSION.
(a) PURPOSE.—It is the purpose of this section to establish a National Health Care Workforce Commission that—
(1) serves as a national resource for Congress, the President, States, and localities; the Departments of Health and Human Services, Labor, Veterans Affairs, Homeland Security, and Education on related activities adminis-
(2) develops and commissions evaluations of education and training activities to deter-
(3) identifies barriers to improved coordination at the Federal, State, and local levels
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and recommend ways to address such barriers; and
(5) encourages innovations to address population needs, constant changes in technology, and other environmental factors.

(ii) VACANCIES.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member was appointed shall hold office only for the remainder of that term and any vacant position shall be filled in the manner in which the original appointment was made.

(C) INITIAL APPOINTMENTS.—The Comptroller General shall make initial appointments of members to the Commission not later than September 30, 2010.

(4) COMPENSATION.—While serving on the business of the Commission (including travel time), a member of the Commission shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code, and travel and subsistence, as authorized by law.

(5) CHAIRMAN, VICE CHAIRMAN.—The Comptroller General shall designate a member of the Commission, at the time of appointment of the member, as Chairman and a member to serve as Vice Chairman for that term of appointment, except that in the case of vacancy of the chairmanship or vice chairmanship, the Comptroller General may designate another member for the remainder of that member’s term.

(6) MEETINGS.—The Commission shall meet at the call of the chairman, but no less frequently than on a quarterly basis.

(D) DUTIES.—

(1) RESEARCH, DISSEMINATION, AND COMMUNICATION.—The Commission shall—

(A) recognize efforts of Federal, State, and local partnerships to develop and offer health care career pathways of proven effectiveness;

(B) disseminate information on promising retention practices for health care professions; and

(C) communicate information on important policies and practices that affect the recruitment, education and training, and retention of the health care workforce.

(2) REVIEW OF HEALTH CARE WORKFORCE AND ANNUAL REPORTS.—In order to develop a financially sustainable integrated workforce that meets the needs of patients and populations, the Commission, in consultation with relevant Federal, State, and local agencies, shall—

(A) review current and project health care workforce supply and demand, including the topics described in paragraph (3);

(B) make recommendations to Congress and the Administration concerning national health care workforce priorities, goals, and policies;

(C) by not later than October 1 of each year (beginning with 2011), submit a report to Congress and the Administration containing the results of such reviews and recommendations concerning health care delivery system that meets the needs of patients and populations, the Commission, in consultation with relevant Federal, State, and local agencies, shall—

(A) review current and project health care workforce supply and demand, including the topics described in paragraph (3);

(B) make recommendations to Congress and the Administration concerning national health care workforce priorities, goals, and policies;

(C) by not later than October 1 of each year (beginning with 2011), submit a report to Congress and the Administration containing the results of such reviews and recommendations concerning

(3) SPECIFIC TOPICS TO BE REVIEWED.—The topics described in this paragraph include—

(A) current health care workforce supply and distribution, including demographics, geographic factors, and demand during the subsequent 10 and 25 year periods;

(B) health care workforce education and training capacity, including the number of students who have completed education and training, including registered apprenticeships; the number of qualified faculty; the availability of and travel to infrastructure; and the education and training demands, with projected demands during the subsequent 10 and 25 year periods;

(C) the education loan and grant programs in titles VII and VIII of the Public Health Service Act (42 U.S.C. 292 et seq. and 296 et seq.) and recommendations on whether such programs should become part of the Higher Education Act of 1965 (20 U.S.C. 1001 et seq.);

(D) the implications of new and existing Federal policies which affect the health care workforce, including Medicare and Medicaid graduate medical education policies, titles VII and VIII of the Public Health Service Act (42 U.S.C. 292 et seq. and 296 et seq.), the National Health Service Corps (with recommendations for aligning such programs with national health workforce priorities and goals), and other health care workforce programs, including those supported through the Workforce Investment Act of 1998 (29 U.S.C. 2901 et seq.), the Carl D. Perkins Career and Technical Education Act of 2006 (20 U.S.C. 2301 et seq.), the Higher Education Act of 1965 (20 U.S.C. 1091 et seq.), and any other Federal health care workforce programs;

(E) the health care workforce needs of special populations, medically underserved populations, gender specific needs, individuals with disabilities, and geriatric and pediatric populations with recommendations for new and existing Federal policies to meet the needs of these special populations; and

(F) recommendations creating or revising national loan repayment programs and scholarship programs to require low-income, minority medical students to serve in their home communities, if designated as medical underserved communities.

(4) HIGH PRIORITY AREAS.—

(A) IN GENERAL.—The initial high priority topics described in this paragraph include each of the following:

(i) Integrated health care workforce planning that identifies health care professional shortages and maximizes the skill sets of health care professionals across disciplines;

(ii) An analysis of the nature, scopes of practice, and demands for health care workforce in the enhanced information technology and management workplace;

(iii) An analysis of how to align Medicare and Medicaid graduate medical education programs with national health workforce priorities and goals;

(iv) The education and training capacity, projected demands, and integration with the health care delivery system of each of the health care delivery system that meets the needs of patients and populations, including demographics, geographic factors, and demand during the subsequent 10 and 25 year periods;

(v) Nursing workforce capacity at all levels;

(II) Oral health care workforce capacity at all levels;

(III) Mental and behavioral health care workforce capacity at all levels;

(IV) Allied health and public health care workforce capacity at all levels;

(V) Emergency medical service workforce capacity, including the retention and recruitment of the volunteer workforce, at all levels;

(VI) The geographic distribution of health care providers as compared to the identified
health care workforce needs of States and regions.

(B) Future Determinations.—The Commission may require that additional topics be included under subparagraph (A). The appropriate committees of Congress may recommend to the Commission the inclusion of other topics for health care workforce development, to the extent such recommendations are consistent with established privacy rules, may secure directly from any department or agency under such section and distribution by the Comptroller General of the United States data on health professional concentrations in a State or area.

(5) Grant Program.—The Commission shall—

(A) review implementation progress reports and report to Congress about the State Health Care Workforce Development Grant program established in section 5102;

(B) in collaboration with the Department of Education, the Department of Labor, and in coordination with the Department of Health and Human Services, make recommendations to Congress on, and report to Congress about, the State Health Care Workforce Development Areas that require special attention.

(C) assess the implementation of the grants under such section; and

(D) collect performance and report information, including identified models and best practices, on grants from the fiscal and administrative agent under such section and distribute it by the Comptroller General of the United States to the appropriate committees of Congress.

(6) Study.—The Commission shall study effective mechanisms for financing education and training for careers in health care, including public health and allied health.

(7) Recommendations.—The Commission shall submit recommendations to Congress, the Department of Labor, and the Department of Health and Human Services about improving safety, health, and worker protections in the workplace for the health care workforce.

(A) Data Collection.—In order to carry out its functions under this section, the Commission shall—

(1) utilize existing information, both published and unpublished, where possible, collected and compiled or otherwise made available to the Commission;

(2) request data from appropriate Federal agencies.

(B) Authority.—The Commission shall study effective mechanisms for financing education and training for careers in health care, including public health and allied health.

(C) Access to Data.—The Commission shall—

(1) access the data collected under subsection (A) of this section;

(2) carry out, or award grants or contracts for the carrying out of, original research and development, where existing information is inadequate, and

(3) adopt procedures allowing interested parties to submit information for the Commission’s use in making reports and recommendations.

(1) Consultation with Federal, State, and Local Agencies, Congress, and Other Organizations.—

(1) in general.—The Commission shall consult with Federal agencies (including the Departments of Labor and Human Services, Labor, Education, Commerce, Agriculture, Defense, and Veterans Affairs and the Environmental Protection Agency), Congress, the Medicare Advisory Commission, the Medicaid and CHIP Payment and Access Commission, the Substance Abuse Prevention and Treatment Interagency Coordinating Committee, and the National Commission on Children’s Mental Health.

(2) Eligibility.—To be eligible to receive a grant under paragraph (3), an entity shall be an entity that—

(1) is a State or political subdivision of a State, a public or private nonprofit educational institution, a public or private health care provider, a private educational institution, or a national organization;

(2) has unrestricted access to all deliberations, documents, information, and data of the Commission; and

(3) shall be included under subparagraph (A).

(3) Eligibility.—To be eligible to receive a grant under paragraph (3), an entity shall be an entity that—

(1) is a State or political subdivision of a State, a public or private nonprofit educational institution, a public or private health care provider, a private educational institution, or a national organization;

(2) has unrestricted access to all deliberations, documents, information, and data of the Commission; and

(3) shall be included under subparagraph (A).

(4) Directing an enrollment.—A State agency that provides grants or contracts for education and training may, in coordination with the appropriate Federal agencies, make recommendations to Congress on, and report to Congress about, the State Health Care Workforce Development Areas that require special attention.

(5) Grant Program.—The Commission shall—

(A) review implementation progress reports and report to Congress about the State Health Care Workforce Development Grant program established in section 5102;

(B) in collaboration with the Department of Education, the Department of Labor, and in coordination with the Department of Health and Human Services, make recommendations to Congress on, and report to Congress about, the State Health Care Workforce Development Areas that require special attention.

(C) assess the implementation of the grants under such section; and

(D) collect performance and report information, including identified models and best practices, on grants from the fiscal and administrative agent under such section and distribute information to Congress, related Federal agencies, make recommendations to Congress, related Federal agencies, and to the public.

(6) Study.—The Commission shall study effective mechanisms for financing education and training for careers in health care, including public health and allied health.

(7) Recommendations.—The Commission shall submit recommendations to Congress, the Department of Labor, and the Department of Health and Human Services about improving safety, health, and worker protections in the workplace for the health care workforce.

A) Data Collection.—In order to carry out its functions under this section, the Commission shall—

(1) utilize existing information, both published and unpublished, where possible, collected and compiled or otherwise made available to the Commission;

(2) request data from appropriate Federal agencies.

(B) Authority.—The Commission shall study effective mechanisms for financing education and training for careers in health care, including public health and allied health.

(C) Access to Data.—The Commission shall—

(1) access the data collected under subsection (A) of this section;

(2) carry out, or award grants or contracts for the carrying out of, original research and development, where existing information is inadequate, and

(3) adopt procedures allowing interested parties to submit information for the Commission’s use in making reports and recommendations.

(1) Consultation with Federal, State, and Local Agencies, Congress, and Other Organizations.—

(1) in general.—The Commission shall consult with Federal agencies (including the Departments of Labor and Human Services, Labor, Education, Commerce, Agriculture, Defense, and Veterans Affairs and the Environmental Protection Agency), Congress, the Medicare Advisory Commission, the Medicaid and CHIP Payment and Access Commission, and, to the extent practicable, with State and local agencies, Indian tribes, voluntary health care providers, professional and voluntary associations, professional societies, and other relevant public-private health care partnerships.

(2) Obtaining Official Data.—The Commission, consistent with established privacy rules, may secure directly from any department or agency of the Executive Branch information necessary to enable the Commission to carry out this section.

(3) Detail of Federal Government Employers.—An employee of the Federal Government may be detailed to the Commission without reimbursement. The detail of such an employee shall be without interruption or loss of civil service status.

(4) Director and Staff; Experts and Consultants.—Subject to such review as the Comptroller General of the United States determines to be necessary to ensure the efficient administration of the Commission, the Commission shall—

(1) employ and fix the compensation of an executive director that shall not exceed the rate of basic pay payable for level V of the Executive Branch.”

United States Code, governing appointments in the competitive service;

(2) seek such assistance and support as may be required in the performance of its duties from appropriate Federal departments and agencies;

(3) enter into contracts or make other arrangements, as may be necessary for the effective performance of the Commission (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));

(4) make advance, progress, and other payments which relate to the work of the Commission;

(5) provide transportation and subsistence for persons serving without compensation; and

(6) prescribe such rules and regulations as the Commission determines to be necessary with respect to the orderly organization and operation of the Commission.

(g) Powers.—

(1) Data Collection.—In order to carry out its functions under this section, the Commission shall—

(1) utilize existing information, both published and unpublished, where possible, collected and compiled or otherwise made available to the Commission;

(2) request data from appropriate Federal agencies.

(B) Authority.—The Commission shall study effective mechanisms for financing education and training for careers in health care, including public health and allied health.

(C) Access to Data.—The Commission shall—

(1) access the data collected under subsection (A) of this section;

(2) carry out, or award grants or contracts for the carrying out of, original research and development, where existing information is inadequate, and

(3) adopt procedures allowing interested parties to submit information for the Commission’s use in making reports and recommendations.

(1) Consultation with Federal, State, and Local Agencies, Congress, and Other Organizations.—

(1) in general.—The Commission shall consult with Federal agencies (including the Departments of Labor and Human Services, Labor, Education, Commerce, Agriculture, Defense, and Veterans Affairs and the Environmental Protection Agency), Congress, the Medicare Advisory Commission, the Medicaid and CHIP Payment and Access Commission, and, to the extent practicable, with State and local agencies, Indian tribes, voluntary health care providers, professional and voluntary associations, professional societies, and other relevant public-private health care partnerships.

(2) Obtaining Official Data.—The Commission, consistent with established privacy rules, may secure directly from any department or agency of the Executive Branch information necessary to enable the Commission to carry out this section.

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(1) Data Collection.—In order to carry out its functions under this section, the Commission shall—

(1) utilize existing information, both published and unpublished, where possible, collected and compiled or otherwise made available to the Commission;

(2) request data from appropriate Federal agencies.
higher education, the recognized State federation, the State public secondary education agency, the State P-16 or P-20 Council if such a council exists, and a philanthropic organization that is actively engaged in providing learning, mentoring, and work opportunities to recruit, educate, and train individuals for, and retain individuals in, careers in health care and related industries.

(3) FISCAL AND ADMINISTRATIVE AGENT.—(A) The Governor of the State receiving a planning grant has the authority to appoint a fiscal and administrative agent for the partnership.

(4) APPLICATION.—Each State partnership described in paragraph (3) shall submit application to the Administrator of the Administration at such time and in such manner, and accompanied by such information as the Administrator determines to be essential to ensure compliance with the grant program requirements.

(5) REQUIRED ACTIVITIES.—A State partnership receiving a planning grant shall carry out the following activities:

(A) Analyze State labor market information in order to create health care career pathways for students and adults, including displaced workers.

(B) Identify current and projected high demand State or regional health care sectors for purposes of planning career pathways.

(C) Describe any Federal, State, and private resources to recruit, educate or train, and retain a skilled health care workforce and strengthen partnerships.

(D) Describe the academic and health care industry skill standards for high school graduation, for entry into postsecondary education, and for various credentials and licenses.

(E) Describe secondary and postsecondary education and training policies, models, or practices for the health care sector, including career information and guidance counseling.

(F) Identify Federal or State policies or rules that are barriers to a comprehensive health care workforce development strategy and barriers and a plan to reduce these barriers.

(G) Participate in the Administration’s evaluation and reporting activities.

(6) PERFORMANCE AND EVALUATION.—Before the State partnership receives a planning grant, the Administrator of the Administration shall jointly determine the performance benchmarks that will be established for the purposes of the planning activities during the duration of the planning grant.

(7) MATCH.—Each State partnership receiving a planning grant shall provide an amount, in cash or in kind, that is not less than 15 percent of the amount of the grant, to carry out the activities supported by the grant. The matching requirement may be provided from funds available under other Federal, State, local, or private sources to carry out the activities.

(8) REPORT.—(A) REPORT TO ADMINISTRATION.—Not later than 1 year after a State partnership receives a planning grant, the partnership shall submit a report to the Administration on the State’s performance of the activities under this section, including the use of the funds, including matching funds, to carry out required activities, and a description of the progress of the State workforce investment board in meeting the performance benchmarks.

(B) REPORT TO CONGRESS.—The Administration shall submit a report to Congress explaining the planning activities, performance, and fund utilization of each State grant recipient, including an identification of promising practices, and a description of the activities of each State grant recipient.

(9) MATCH.—Each State partnership receiving an implementation grant shall—

(A) competitively award implementation grants to State partnerships to enable such partnerships to implement activities that will result in a coherent and comprehensive plan for health workforce development that will address current and projected workforce demands within the State; and

(B) inform the Commission and Congress about the awards made.

(2) DURATION.—An implementation grant shall be awarded for a period of no more than 2 years, except in those cases where the Administration determines that the grantee is high performing and the activities supported by the grant warrant up to 1 additional year of funding.

(3) ELIGIBILITY.—To be eligible for an implementation grant, a State partnership shall have—

(A) received a planning grant under subsection (c) and completed all requirements of such grant;

(B) completed a satisfactory application, including a plan to coordinate with required partners and complete the required activities during the 2 year period of the implementation grant.

(4) FISCAL AND ADMINISTRATIVE AGENT.—A State partnership receiving an implementation grant shall appoint a fiscal and administrative agent for the implementation of such grant.

(5) APPLICATION.—Each eligible State partnership receiving an implementation grant shall submit an application to the Administration at such time, in such manner, and accompanied by such information as the Administrator determines to be necessary to ensure compliance with the grant program requirements.

(6) REQUIRED ACTIVITIES.—A State partnership receiving an implementation grant shall—

(A) submit an application to the Administration in order to create health care career pathways at the regional and State levels, curricula for health career opportunities to recruit, educate, and train, and retain a skilled health care workforce and strengthen partnerships;

(B) identify current and projected workforce requirements, including changes in State or local policies to foster coherent and comprehensive health care workforce development activities, including health care career pathways at the regional and State levels, curricula for health career opportunities to recruit, educate, and train, and retain a skilled health care workforce and strengthen partnerships;

(C) provide an amount, in cash or in kind, that is not less than 15 percent of the amount of the grant, to carry out the activities supported by the grant.

(7) PERFORMANCE AND EVALUATION.—Before the State partnership receives an implementation grant, it and the Administrator shall jointly determine the performance benchmarks that shall be established for the purposes of the implementation grant.

(8) MATCH.—Each State partnership receiving an implementation grant shall provide an amount, in cash or in kind, that is not less than 15 percent of the amount of the grant, to carry out the activities supported by the grant. The matching funds may be provided from funds available from other Federal, State, local, or private sources to carry out such activities.

(9) REPORTS.—(A) REPORT TO ADMINISTRATION.—For each year of the implementation grant, the State partnership receiving the implementation grant shall submit a report to the Administration on the performance of the State partnership activities, including a description of the use of the funds, including matching funds, to complete activities, and a description of the performance of the State partnership in meeting the performance benchmarks.

(B) REPORT TO CONGRESS.—The Administration shall submit a report to Congress analyzing implementation activities, performance, and fund utilization of the State grants, including an identification of promising practices and a profile of the activities of each State grant.

(e) AUTHORIZATION FOR APPROPRIATIONS.—(1) PLANNING GRANTS.—There are authorized to be appropriated to award planning grants under subsection (b) not to exceed $10,000,000 in fiscal year 1999 and $8,000,000 for each of fiscal years 2000 through 2010, and such sums as may be necessary for each subsequent fiscal year.
SEC. 5103. HEALTH CARE WORKFORCE ASSESSMENT.

(a) IN GENERAL.—Section 761 of the Public Health Service Act (42 U.S.C. 294m) is amended—

(1) by redesignating subsection (c) as subsection (e); and

(2) by striking subsection (b) and inserting the following:

"(b) NATIONAL CENTER FOR HEALTH CARE WORKFORCE ANALYSIS.—

"(1) ESTABLISHMENT.—The Secretary shall establish the National Center for Health Workforce Analysis (referred to in this section as the "National Center").

"(2) PURPOSES.—The National Center, in coordination to the extent practicable with the National Health Care Workforce Commission (established in section 5301 of the Patient Protection and Affordable Care Act), and relevant regional and State centers and agencies, shall—

(A) provide for the development of information describing and analyzing the health care workforce and workforce related issues; and

(B) carry out the activities under section 762(a).

"(3) COLLABORATION AND DATA SHARING.—

"(A) IN GENERAL.—The National Center shall collaborate with Federal agencies and relevant professional and educational organizations or societies for the purpose of linking data regarding grants awarded under this title.

"(B) CONTRACTS FOR HEALTH WORKFORCE ANALYSIS.—For the purpose of carrying out the activities described in subparagraph (A), the National Center may enter into contracts with a public or private entity under this title and a database to collect data from longitudinal evaluations (as described in subsection (d)(2)) on performance measures (as developed under sections 749(d)(3), 757(d)(3), and 762(a)(3)).

"(4) ANNUALLY EVALUATE PROGRAMS.—The National Center shall carry out an evaluation of programs under this title;

"(D) develop and publish performance measures and benchmarks for programs under this title; and

"(E) establish, maintain, and publicize a national Internet registry of each grant awarded under this title and a database to collect data from longitudinal evaluations (as described in subsection (d)(2)) on performance measures (as developed under sections 749(d)(3), 757(d)(3), and 762(a)(3)).

"(3) COLLABORATION AND DATA SHARING.—

"(A) IN GENERAL.—The National Center shall collaborate with Federal agencies and relevant professional and educational organizations or societies for the purpose of linking data regarding grants awarded under this title.

"(B) CONTRACTS FOR HEALTH WORKFORCE ANALYSIS.—For the purpose of carrying out the activities described in subparagraph (A), the National Center may enter into contracts with a public or private entity under this title and a database to collect data from longitudinal evaluations (as described in subsection (d)(2)) on performance measures (as developed under sections 749(d)(3), 757(d)(3), and 762(a)(3)).

"(C) UTILIZES A LONGITUDINAL EVALUATION.—To utilize a longitudinal evaluation (as described in section 761(d)(2)) for programs under this title, except for programs under part C or D;

"(4) USE OF LONGITUDINAL EVALUATIONS.—

Section 791(a)(1) of the Public Health Service Act (42 U.S.C. 295(a)(1)) is amended—

(1) in subparagraph (A), by striking "or" at the end;

(2) in subparagraph (B), by striking the period after "and" and inserting "; or";

and

(3) by adding at the end the following:

"(C) utilizes a longitudinal evaluation (as described in section 761(d)(2)) for programs under this title, except for programs under part C or D;''.

"(B) PERFORMANCE MEASURES; GUIDELINES FOR LONGITUDINAL EVALUATIONS.—

(1) ADVISORY COMMITTEE ON TRAINING IN PRIMARY CARE MEDICINE AND DENTISTRY.—

Section 748(d) of the Public Health Service Act (42 U.S.C. 292d) is amended—

(A) in subsection (a), by striking "part;'' and

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

"The loan is repaid in full, whichever occurs first.'';

"(C) ELIGIBLE ENTITIES.—To be eligible for a grant or contract under this section, an entity shall—

(A) be a State, a State workforce investment board, a public health or health professions school, an academic health center, or an appropriate public or private nonprofit entity; and

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

(2) INCREASE IN GRANTS FOR LONGITUDINAL EVALUATIONS.—

"(1) IN GENERAL.—The Secretary shall increase the amount awarded to an eligible entity under this title for a longitudinal evaluation of individuals who have received education, training, or financial assistance from programs under this title.

"(2) CAPABILITY.—A longitudinal evaluation shall be capable of—

(A) identifying patterns and trends; and

(B) collecting and reporting data on performance measures developed under sections 749(d)(3), 757(d)(3), and 762(a)(3).

"(3) GUIDELINES FOR LONGITUDINAL EVALUATION SHALL COMPLY WITH GUIDELINES ISSUED UNDER SECTIONS 749(d)(4), 757(d)(4), AND 762(a)(4).

"(4) ELIGIBLE ENTITIES.—To be eligible to obtain an increase under this section, an entity shall be a recipient of a grant or contract under this title.''; and

(3) ADVISORY COMMITTEE ON GRADUATE MEDICAL EDUCATION.—

Section 762(a) of the Public Health Service Act (42 U.S.C. 294o(a)) is amended—

(A) in paragraph (1), by striking "and" at the end;

(B) in paragraph (2), by striking the period and inserting a semicolon; and

(C) by adding at the end the following:

"(3) develop, publish, and implement performance measures for programs under this title, except for programs under part C or D;''.

(B) IN GENERAL.—Section 741 of the Public Health Service Act (42 U.S.C. 292c) is amended—

"(1) IN GENERAL.—The Secretary shall carry out an evaluation of individuals who have received education, training, or financial assistance from programs under this title.

"(2) CAPABILITY.—A longitudinal evaluation shall be capable of—

(A) identifying patterns and trends; and

(B) collecting and reporting data on performance measures developed under sections 749(d)(3), 757(d)(3), and 762(a)(3).

"(3) GUIDELINES FOR LONGITUDINAL EVALUATION SHALL COMPLY WITH GUIDELINES ISSUED UNDER SECTIONS 749(d)(4), 757(d)(4), AND 762(a)(4).

"(4) ELIGIBLE ENTITIES.—To be eligible to obtain an increase under this section, an entity shall be a recipient of a grant or contract under this title.''; and

 begr thanks for providing the text.
SEC. 5203. HEALTH CARE WORKFORCE LOAN REPAYMENT PROGRAMS.

Part B of title VII of the Public Health Service Act (42 U.S.C. 294n et seq.) is amended by adding at the end the following:

"Subpart 3—Recruitment and Retention Programs"

"SEC. 775. INVESTMENT IN TOMORROW'S PEDIATRIC MEDICAL SPECIALISTS.

"(a) Establishment.—The Secretary shall establish and carry out a pediatric specialty loan repayment program under which eligible individuals agree to be employed pursuant to the program for a specified period (which shall not be less than 2 years) in providing pediatric medical subspecialty, pediatric surgical specialty, or child and adolescent mental and behavioral health care, including substance abuse prevention and treatment services.

"(b) Program Administration.—Through the program established under this section, the Secretary shall enter into contracts with qualified health professionals under which—

"(1) such qualified health professionals will agree to practice in a pediatric medical subspecialty, pediatric surgical specialty, or child and adolescent mental and behavioral health care in an area with a shortage of the specified health care specialty area (as designated by the Secretary) for a sufficient pediatric population to support such pediatric subspecialty, as determined by the Secretary; and

"(2) the Secretary agrees to make payments to the principal and interest of—

"(A) student loans (as defined in subsection (d)(1)(B) of section 294a-1 of the Public Health Service Act (42 U.S.C. 294a-1(d)(1)(B)) of an eligible individual unless the contract specifies otherwise; or

"(B) other pre-kindergarten, elementary, or secondary education expenses of the eligible individual.

"(c) Eligibility requirements.—The Secretary may enter into contracts under this section only—

"(1) with an eligible individual—

"(i) who agrees to practice in the area of clinical experience in child and adolescent mental health in psychiatry, psychology, psychiatric nursing, school social work, school psychology, behavioral pediatrics, psychiatric nursing, social work, school social work, substance abuse disorder prevention and treatment, marriage and family therapy, school counseling, or professional counseling;

"(ii) has a license or certification in a State to practice allopathic medicine, osteopathic medicine, psychology, school psychology, psychiatric nursing, social work, marriage and family therapy, school counseling, or professional counseling; or

"(iii) is a mental health professional who—

"(A) is entering or receiving training in an accredited specialized training or clinical experience program or course described in paragraph (2); or

"(B) is or has been employed by, or has accepted employment with, a Federal, State, local, or tribal public health agency or a related training fellowship, as recognized by the Secretary;

"(2) in an area with a pediatric medical subspecialty or pediatric surgical specialty shortage in Federal, State, local, or tribal public health agency or a related training fellowship, as recognized by the Secretary; and

"(3) has been employed in an area described in paragraph (2)(B) for a period of at least 2 years.

"(d) Payment.—The Secretary shall make—

"(1) a payment to an eligible individual, for each year of service under a contract entered into under this section, equal to the amount of—

"(A) the annual market rate of return on long-term, risk-free United States Treasury securities, multiplied by—

"(B) the present value of the individual's United States dollar salary, plus

"(C) the present value of the individual's expenses related to the provision of medical services, plus

"(D) any required contributions to an employee benefit plan;

"(2) a payment to the Secretary for each year of obligated service that an eligible individual incurs, equal to—

"(A) the individual loans incurred by the Secretary that the Secretary will repay on behalf of the eligible individual; and

"(B) the Secretary's reasonable costs in providing the loan repayment program.

"(e) Authorization of Appropriations.—There is authorized to be appropriated $30,000,000 for each of fiscal years 2010 through 2014 to carry out subsection (c).

"SEC. 5204. PUBLIC HEALTH WORKFORCE RECRUITMENT PROGRAMS.

"(a) Establishment.—The Secretary shall establish a Public Health Workforce Loan Repayment Program (referred to in this section as the 'Program') to assure an adequate supply of public health professionals to eliminate critical public health workforce shortages in Federal, State, local, and tribal public health agencies.

"(b) Eligibility.—To be eligible to participate in the Program, an eligible individual—

"(1) must be employed, or have accepted employment, in a school or other pre-kindergarten, elementary, or secondary educational institution in a State or territory in the final year of a course of study or program leading to a public health or health professions degree or certificate; and

"(2) must have accepted employment with, or have been employed by, a Federal, State, local, or tribal public health agency.

"(c) Payment.—For each year of obligated service that an eligible individual incurs under a written contract entered into under this section, the Secretary may pay—

"(1) an amount equal to the individual's reasonable expenses related to the provision of medical services; and

"(2) an amount equal to the individual's reasonable compensation for each year of obligated service.

"(d) Authorization of Appropriations.—There is authorized to be appropriated $30,000,000 for each of fiscal years 2010 through 2014 to carry out subsection (c)."
(e) POSTPONING OBLIGATED SERVICE.—With respect to an individual receiving a degree or certificate from a health professions or other related school, the date of the initiation of a period of obligated service may be postponed as approved by the Secretary.

(f) BREACH OF CONTRACT.—An individual who breaches the contract entered into under subsection (c) shall be subject to the same financial penalties as provided for under section 335E for breaches of loan repayment contracts under section 338B.

(g) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $155,000,000 for fiscal year 2010, and such sums as may be necessary for each of fiscal years 2011 through 2015.

SEC. 2508. ALLIED HEALTH WORKFORCE RECRUITMENT AND RETENTION PROGRAMS.

(a) PURPOSE.—The purpose of this section is to assure an adequate supply of allied health professionals to eliminate critical allied health workforce shortages in Federal, State, local, and tribal public health agencies or in settings where patients may require health care services, including acute care facilities, ambulatory care facilities, personal residences and other settings located in medically underserved areas or medically underserved populations, as recognized by the Secretary of Health and Human Services or other related school, the date of the initiation of a period of obligated service may be postponed as approved by the Secretary.

SEC. 2509. ALLIED HEALTH WORKFORCE RECRUITMENT AND RETENTION PROGRAMS.—Section 428K of the Higher Education Act of 1965 (20 U.S.C. 1087k) is amended by—

(1) in subsection (b), by adding at the end the following:

"(18) ALLIED HEALTH PROFESSIONALS.—The term 'allied health professionals' means—";

(2) in subsection (g), by—

(A) redesignating paragraphs (1) through (6) as paragraphs (2) through (7), respectively; and

(B) by inserting before paragraph (2) (as redesignated by subparagraph (A)) the following:

"(1) ELIGIBLE ENTITY.—The term 'eligible entity' includes—";

(3) in subsection (h), by—

(A) redesignating paragraphs (1) through (8) as paragraphs (2) through (9), respectively; and

(B) by inserting before paragraph (2) (as redesignated by subparagraph (A)) the following:

"(2) ELIGIBLE INDIVIDUAL.—The term 'eligible individual' includes—";

(4) in subsection (i), by—

(A) redesignating paragraphs (1) through (4) as paragraphs (2) through (5), respectively; and

(B) by inserting before paragraph (2) (as redesignated by subparagraph (A)) the following:

"(1) ALLIED HEALTH PROFESSIONALS.—The term 'allied health professional' means—";

SEC. 2507. FEDERAL AND NATIONAL HEALTH SERVICE CORPS.

Section 338H(a) of the Public Health Service Act (42 U.S.C. 254h(a)) is amended to read as follows:

"(a) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there is authorized to be appropriated, out of any funds in the Treasury not otherwise appropriated, the following:

(1) For fiscal year 2010, $320,461,632.

(2) For fiscal year 2011, $338,067,442.

(3) For fiscal year 2012, $356,413,432.

(4) For fiscal year 2013, $374,856,433.

(5) For fiscal year 2014, $393,291,336.

(6) For fiscal year 2015, $414,095,394.

(7) Fifty percent shall be allotted to public health mid-career professionals and 50 percent shall be allotted to allied health mid-career professionals.

(b) ELIGIBILITY.—(1) ELIGIBLE ENTITY.—The term 'eligible entity' includes—";

(2) in paragraph (3), by—

(A) redesignating paragraphs (1) through (3) as paragraphs (2) through (4), respectively; and

(B) by inserting before paragraph (2) (as redesignated by subparagraph (A)) the following:

"(1) ELIGIBLE INDIVIDUAL.—The term 'eligible individual' includes—";

(3) in paragraph (6), by—

(A) redesignating paragraphs (1) through (4) as paragraphs (2) through (5), respectively; and

(B) by inserting before paragraph (2) (as redesignated by subparagraph (A)) the following:

"(1) ALLIED HEALTH PROFESSIONALS.—The term 'allied health professional' means—";

SEC. 2508. NURSE-MANAGED HEALTH CLINICS.

(a) PURPOSE.—The purpose of this section is to fund the development and operation of nurse-managed health clinics.

(b) GRANTS.—Subpart 1 of part D of title III of the Public Health Service Act (42 U.S.C. 254n et seq.) is amended by—

"(1) COMPREHENSIVE PRIMARY HEALTH CARE SERVICES.—In this section, the term 'comprehensive primary health care services' means the primary health services described in section 330(b)(1).

"(2) NURSE-MANAGED HEALTH CLINIC.—The term 'nurse-managed health clinic' means a nurse-managed health clinic operated by an advanced practice nurse, that provides primary care or wellness services to underserved or vulnerable populations and that is affiliated with a school, college, university, or other related school, the date of the initiation of a period of obligated service may be postponed as approved by the Secretary.

"(3) AUTHORITY TO AWARD GRANTS.—The Secretary shall award grants for the operation of nurse-managed health clinics that meet the requirements of this section.

"(c) APPLICATIONS.—To be eligible to receive a grant under this section, an entity shall—

(1) be an NHMC; and

(2) submit to the Secretary an application at such time, in such manner, and containing—";

(4) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated $50,000,000 for the fiscal year 2010 and such sums as may be necessary for each of fiscal years 2011 through 2014.

SEC. 2509. ELIMINATION OF CAP ON COMMISSIONED CORPS.

Section 203 of the Department of Health and Human Services Appropriations Act, 1993 (Public Law 102-394) is amended by striking "not to exceed 2,800".

SEC. 2510. ESTABLISHING A READY RESERVE CORPS.

Section 203 of the Public Health Service Act (42 U.S.C. 204) is amended to read as follows:

"(a) ESTABLISHMENT.—";

(1) in general.—There shall be in the Service a commissioned Regular Corps and a Ready Reserve Corps for service in time of national emergency.

("(2) REQUIREMENT.—All commissioned officers shall be citizens of the United States and shall be appointed without regard to the civil-service laws and compensated without regard to the Classification Act of 1923, as amended.

("(3) APPOINTMENT.—Commissioned officers of the Ready Reserve Corps shall be appointed by the President and commissioned officers of the Regular Corps shall be appointed by the President with the advice and consent of the Senate.

("(4) ACTIVITY.—Commissioned officers of the Ready Reserve Corps shall at all times
be subject to call to active duty by the Surgeon General, including active duty for the purpose of training.

(5) WARRANT OFFICERS.—Warrant officers may be authorized to serve in the Ready Reserve Corps for the purpose of providing support to the health and delivery systems maintained by the Service and any warrant officer appointed to the Service Reserve is required to preserve and to defend the government of the United States under this Act and title 37, United States Code, to be a commissioned officer within the Commissioned Corps of the Service.

(b) ASCERTAINING RESERVE CORPS OFFICERS INTO THE REGULAR CORPS.—Effective on the date of enactment of the Patient Protection and Affordable Care Act, all individuals classified as Reserve Corps officers under this section (as such section existed on the day before the date of enactment of such Act) and serving on active duty shall be deemed to be commissioned officers of the Regular Corps.

(4) PURPOSE AND USE OF READY RESERVE.—

(1) Purpose.—The purpose of the Ready Reserve Corps is to fulfill the need to have additional Commissioned Corps personnel available on short notice (similar to the uniformed service reserve program) to assist regular Commissioned Corps personnel to meet both routine public health and emergency response missions.

(2) Uses.—The Ready Reserve Corps shall—

(A) participate in routine training to meet the general and specific needs of the Commissioned Corps;

(B) be available and ready for involuntary calls to active duty during national emergencies and public health crises, similar to the uniformed service reserve personnel;

(C) be available for backfilling critical positions left vacant during deployment of active duty Commissioned Corps members, as well as to respond to public health emergencies, both foreign and domestic; and

(D) be available for service assignment in isolated, hardship, and medically underserved communities (as defined in section 799B) to improve access to health services.

(3) FUNDING.—For the purpose of carrying out the duties and responsibilities of the Commissioned Corps under this section, there are authorized to be appropriated $5,000,000 for fiscal year 2014 for recruitment and training and $12,500,000 for each of fiscal years 2010 through 2014 for the Ready Reserve Corps.

Subtitle D—Enhancing Health Care Workforce Education and Training

SEC. 5301. TRAINING IN FAMILY MEDICINE, GENERAL INTERNAL MEDICINE, GENERAL PEDIATRICS, AND PHYSICIAN ASSISTANT EDUCATION PROGRAMS

Part C of title VII (42 U.S.C. 293k et seq.) is amended by striking section 747 and inserting the following:

SEC. 747. PRIMARY CARE TRAINING AND ENHANCEMENT.

(1) SUPPORT AND DEVELOPMENT OF PRIMARY CARE TRAINING PROGRAMS.—

(A) In General.—The Secretary may make grants to, or enter into contracts with, an accredited public or nonprofit private hospital, school of medicine or osteopathic medicine, or school of nursing, for the purpose of carrying out such programs in areas where there is a demonstrated need.

(B) To plan, develop, and operate a program for the training of physicians who plan to teach in family medicine, general internal medicine, or general pediatrics training programs.

(C) To plan, develop, and operate a program for the training of physicians teaching in community-based settings.

(D) To provide financial assistance in the form of traineeships and fellowships to physicians who are participants in any such programs and who plan to teach or conduct research in a family medicine, general internal medicine, or general pediatrics training program.

(E) To provide training in the form of traineeships and fellowships to physicians who are participants in any such programs and who plan to teach or conduct research in a family medicine, general internal medicine, or general pediatrics training program.

(F) To plan, develop, and operate a physician assistant education program, and for the training of individuals who will teach in programs that prepare physician assistants.

(G) To plan, develop, and operate a demonstration program that provides training in new competencies, as recommended by the Advisory Committee on Training in Primary Care Medicine and Dentistry and the National Health Care Workforce Commission established in section 5101 of the Patient Protection and Affordable Care Act, which may include—

(i) providing training to primary care physicians relevant to providing care through patient-centered medical homes; and

(ii) developing tools and curricula relevant to patient-centered medical homes; and

(H) To plan, develop, and operate joint degree programs to provide interdisciplinary and interprofessional graduate training in public health for other health professionals to provide training in environmental health, infectious disease control, disease prevention and health promotion, epidemiological studies and injury control.

(2) DURATION OF AWARDS.—The period during which payments are made to an entity from an award of a grant or contract under this subsection shall be 5 years.

SEC. 5302. TRAINING OPPORTUNITIES FOR DIRECT CARE WORKERS

Part C of title VII of the Public Health Service Act (42 U.S.C. 293k et seq.) is amended by inserting after section 747, as amended by section 5301, the following:

SEC. 747A. TRAINING OPPORTUNITIES FOR DIRECT CARE WORKERS.

(a) In General.—The Secretary shall award grants to eligible entities to enable the recipients to provide training programs to direct care workers who are employed in long-term care settings such as

(b) Capacity Building in Primary Care.

(1) In General.—The Secretary may make grants to or enter into contracts with, an accredited school of medicine or osteopathic medicine to establish, maintain, or improve—

(A) academic units or programs that improve clinical teaching and research in fields defined in subsection (a)(1)(A); or

(B) programs that integrate academic administrative units in fields defined in subsection (a)(1)(A) to enhance interdisciplinary training, and faculty development.

(2) Preference in Making Awards Under This Subsection.—In making awards of grants and contracts under paragraph (1), the Secretary shall give preference to any qualified applicant that demonstrates a significant improvement in the percentage of providers, or that have demonstrated significant improvements in the percentage of providers trained, who enter and remain in primary care practice.

SEC. 5303. TRAINING PROGRAMS FOR EMERGENCIES AND DISASTERS

Part C of title VII of the Public Health Service Act (42 U.S.C. 293k et seq.) is amended by inserting after section 747, as amended by section 5301, the following:

SEC. 747A. TRAINING OPPORTUNITIES FOR DIRECT CARE WORKERS.

(a) In General.—The Secretary shall award grants to eligible entities to enable the recipients to provide training programs to direct care workers who are employed in long-term care settings such as
nursing homes (as defined in section 1906(e)(1) of the Social Security Act (42 U.S.C. 1396(e)(1)), assisted living facilities and skilled nursing facilities, intermediate care facilities for individuals with mental retardation, home and community based settings, and any other setting the Secretary determines to be appropriate.

(6) The Secretary shall award, in each case where appropriate, grants to, or contracts with, entities that have programs to train individuals to work in settings, such as older adults, homeless individuals, victims of abuse or trauma, individuals with mental health or substance-related disorders, individuals with disabilities, and individuals with HIV/AIDS, and in the risk-based clinical disease management of all populations.

(7) The Secretary, in consultation with the agencies described in section 5302, shall develop appropriate standards of performance, uniform policies for the administration of funds, and a system of monitoring and evaluation to ensure that programs funded under this section are effective.

SEC. 5303. TRAINING IN GENERAL, PEDIATRIC, AND PUBLIC HEALTH DENTISTRY.

Part C of Title VII of the Public Health Service Act (42 U.S.C. 293 et seq.) is amended by-

(1) redesignating section 748, as amended by section 5103 of this Act, as section 749; and
(2) inserting after section 747A, as added by section 5302, the following:

SEC. 749. TRAINING IN GENERAL, PEDIATRIC, AND PUBLIC HEALTH DENTISTRY.

(a) SUPPORT AND DEVELOPMENT OF DENTAL TRAINING PROGRAMS.

(1) IN GENERAL.—The Secretary may make grants to, or enter into contracts with, a school of dentistry, public or nonprofit private hospital, or a public or private nonprofit organization which the Secretary determines to be appropriate, for training individuals who are in need thereof, who are participants in any such program, to work in settings, such as older adults, homeless individuals, victims of abuse or trauma, and individuals with disabilities, and in the risk-based clinical disease management of all populations.

(2) MANNER OF PAYMENTS.—With respect to the payments described in subparagraph (A), each grant shall be payable in semiannual installments.

(3) ELIGIBLE ENTITIES.—For the purpose of carrying out subsections (a), (b), and (c), there is authorized to be appropriated $30,000,000 for fiscal year 2010 and such sums as may be necessary for each of fiscal years 2011 through 2015.

(4) ELIGIBLE INDIVIDUALS.—Eligible individuals are awarded grants under this section shall be individuals who have a record of training in general, pediatric, and public health dentistry for a period of at least 2 years and who are capable of carrying out such grant or contract, and who have demonstrated a commitment to work in settings, such as older adults, homeless individuals, victims of abuse or trauma, and individuals with disabilities, and in the risk-based clinical disease management of all populations.

(5) DURATION OF AWARD.—The period of the grant or contract shall be not less than 2 years and not more than 3 years.
(1) be—

(A) an institution of higher education, including a community college;

(B) a public-private partnership;

(C) a health center; or

(D) an Indian Health Service facility or a tribe or tribal organization (as such terms are defined in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 460a-10)).

(2) have the experience and resources to provide comprehensive geriatric education.

SEC. 5305. GERIATRIC EDUCATION AND TRAINING INCENTIVE AWARDS: COMPREHENSIVE GERIATRIC EDUCATION.

(a) Workforce Development; Career Awards.—(1) Pursuant to paragraph (3), a geriatric education center that receives an award under this subsection shall use such funds to offer short-term intensive courses designed to increase the knowledge as (referred to in this section as a ‘fellowship’) that focus on geriatrics, chronic care management, and long-term care that provide supplemental training for faculty members in medicine, nursing, and other health professions schools with programs in psychology, pharmacy, nursing, social work, dentistry, public health, allied health, or other health disciplines, as approved by the Secretary.

(b) Subsequent Disbursements.—The remaining amount of grant funds not dispersed under paragraph (1) shall be dispersed such that not less than 15 percent of such remaining amount is dispersed each subsequent year.

(c) Compliance With State Requirements.—Each entity receiving a grant under this section shall comply with the State education system plan for meeting the educational needs in the fields of geriatrics, long-term care, and chronic care management.

(d) Eligible Individuals.—To be eligible to receive an award under paragraph (1), an individual shall—

(A) be an advanced practice nurse, a clinical social worker, a pharmacist, or other individual who is pursuing a degree in geriatrics or have completed a fellowship ('fellowship') that focus on geriatrics, chronic care management, and long-term care; and

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

(2) have an established record of providing care services for older adults and other long-term care services.

(3) be an institution that has a current faculty, and appropriately credentialed volunteer faculty and practitioners, who do not have formal training in geriatrics, to improve their knowledge and clinical skills for the care of older adults and adults with functional limitations and to enhance their interdisciplinary teaching skills.

(4) by striking paragraph (2) through paragraph (6), respectively; and

(5) the recipient shall agree to subsequently provide a minimum of 10 hours of voluntary instructional support through a geriatric education center to support the recipient.

(6) evaluation.—Participation in a fellowship under this paragraph shall be accepted with respect to complying with continuing health profession education requirements.

(A) Family Caregiver and Direct Care Provider Training.—A geriatric education center that receives an award under this subsection shall use such funds to offer a fellowship program in geriatrics to support the recipient.

(B) CME Credit.—Participation in a fellowship under this paragraph shall use such funds to offer a fellowship program in geriatrics to support the recipient.

(C) State Requirements.—Each entity receiving a grant under this subsection shall comply with the State education system plan for meeting the educational needs in the fields of geriatrics, long-term care, and chronic care management.

(2) Eligible Individuals.—To be eligible to receive an award under paragraph (1), an individual shall—

(A) be an advanced practice nurse, a clinical social worker, a pharmacist, or other individual who is pursuing a degree in geriatrics or have completed a fellowship ('fellowship') that focus on geriatrics, chronic care management, and long-term care; and

(B) be a board certified or board eligible in internal medicine, family practice, psychiatry, or licensed dentistry, or have completed any required training in a discipline and employed in an accredited health profession school that is approved by the Secretary.

(3) Incorporation of Best Practices.—A geriatric education center that receives an award under this subsection shall—

(a) develop and include material on depression and other mental disorders common among older adults, medication safety issues for older adults, psychosocial and behavioral aspects of dementia and communication techniques with individuals who have dementia in all training courses, where appropriate.

(b) Target.—A geriatric education center that receives an award under this subsection shall be required by the Secretary for providing geriatric training to a certain number of faculty or practitioners during the term of the award, as well as any other parameters established by the Secretary.

(4) Amount of Award.—An award under this subsection shall be in an amount that is not less than $50,000. Not more than 24 geriatric education centers may receive an award under this subsection.

(5) Maintenance of Effort.—A geriatric education center that receives an award under this subsection shall provide assurances to the Secretary that funds provided to the geriatric education center under this subsection will be used only to supplement, not to supplant, the amount of Federal, State, and local funds otherwise expended by the geriatric education center.

(6) Authorization of Appropriations.—In addition to any other funding available to carry out this section, there is authorized to be appropriated, for the period of fiscal year 2011 through 2014, $3,000,000.

(7) Authorization of Appropriations.—In addition to any other funding available to carry out this section, there is authorized to be appropriated, for the period of fiscal year 2011 through 2014, $3,000,000.

(8) Maintenance of Effort.—A geriatric education center that receives an award under this subsection shall provide assurances to the Secretary that funds provided to the geriatric education center under this subsection will be used only to supplement, not to supplant, the amount of Federal, State, and local funds otherwise expended by the geriatric education center.

(9) Authorization of Appropriations.—In addition to any other funding available to carry out this section, there is authorized to be appropriated, for the period of fiscal year 2011 through 2014, $3,000,000.

(10) Authorization of Appropriations.—In addition to any other funding available to carry out this section, there is authorized to be appropriated, for the period of fiscal year 2011 through 2014, $3,000,000.
“(C) have a junior (non-tenured) faculty appointment at an accredited (as determined by the Secretary) school of medicine, osteopathic medicine, nursing, social work, psychology, pharmacy, or other allied health disciplines in an accredited health professions school that is approved by the Secretary.

“(3) INSTITUTIONAL REQUIREMENT.—For no grant under this subsection—

(A) are accredited by the Council on Social Work Education, the National Council of Social Work Accreditation, or any successor thereto; and

(B) exhibit an ability to recruit social workers from and place social workers in communities where there are the greatest needs for social workers; and

(C) have a full time faculty appointment in an accredited health professions school and have collaborated with health professions schools, mental health organizations, and other professionals serving high-priority populations and are able to demonstrate an ability to recruit social workers from and place social workers in communities where there are the greatest needs for social workers; and

(D) establish traineeships for individuals who are preparing for advanced education degrees in geriatric nursing, long-term care, geropsychiatric nursing or other nursing areas that specialize in the care of the elderly population; and

(E) provide services through a community mental health program described in section 1913(b)(1).

“SEC. 5307. CULTURAL COMPETENCY, PREVENTION, AND PUBLIC HEALTH AND INDIVIDUALS WITH DISABILITIES TRAINING.

(a) TITLE VII.—Section 741 of the Public Health Service Act (42 U.S.C. 298c) is amended—

(1) in subsection (a)—

(A) by striking the subsection heading and inserting “CULTURAL COMPETENCY, PREVENTION, AND PUBLIC HEALTH AND INDIVIDUALS WITH DISABILITIES GRANTS”; and

(B) by striking paragraph (1), by striking “for the purpose of and all that follows through the period at the end and inserting “for the purpose of” and all that follows through the period at the end; and inserting “for the purposes determined as appropriate by the Secretary.”; and

(2) by striking subsection (b) and inserting the following:

“(b) COLLABORATION.—In carrying out subsection (a), the Secretary shall collaborate with health professions schools, mental health organizations, and other community-based organizations, and other organizations as determined appropriate by the Secretary.”.
Secretary. The Secretary shall coordinate with curricula and research and demonstration projects developed under section 807.

(d) Dissemination.—Model curricula developed under this section shall be disseminated through the Internet Clearinghouse under section (a) and such other means as determined appropriate by the Secretary.

(2) Evaluation.—The Secretary shall evaluate the adoption and the implementation of the curricula, training, and such other means as determined appropriate by the Secretary.

(3) Authorization of Appropriations.—There is authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2010 through 2015.

SEC. 5308. ADVANCED NURSING EDUCATION GRANTS.

Section 811 of the Public Health Service Act (42 U.S.C. 296c-1) is amended—

(A) in subsection (a)—

(1) in paragraph (1), by striking "and nurse midwifery programs" and inserting "and nurse midwifery programs; and

(2) in paragraph (2) and (3), by striking "baccalaureate prepared registered nurses or nurse midwives" and inserting "baccalaureate prepared registered nurses or nurse midwives and advanced practice nurses or nurse midwives";

(B) by redesigning subsections (d), (e), and (f) as subsections (e), (f), and (g), respectively; and

(C) by inserting after subsection (c), the following:

"(d) Authorized Nurse-Midwifery Programs.—Midwifery programs that are eligible for grants under this section are educational programs that—

(1) have as their objective the education of midwives; and

(2) are accredited by the American College of Nurse-Midwives Accreditation Commission for Midwifery Education.".

SEC. 5309. NURSE EDUCATION, PRACTICE, AND RETENTION GRANTS.

(a) In General.—Section 831 of the Public Health Service Act (42 U.S.C. 296b) is amended—

(1) in the section heading, by striking "RETENTION" and inserting "QUALITY";

(2) in subsection (a), by redesignating paragraph (3) as paragraph (2);

(3) in subsection (b), by striking "managed care, quality improvement" and inserting "coordinated care, quality improvement";

(4) in subsection (g), by inserting "as defined in section 801(2)," after "school of nursing"; and

(5) in subsection (h), by striking "2003 through 2007" and inserting "2010 through 2014".

(b) Nurse Retention Grants.—Title VIII of the Public Health Service Act is amended by inserting after section 831 (42 U.S.C. 296b) the following:

"SEC. 831A. NURSE RETENTION GRANTS.

(a) Retention Priority Areas.—The Secretary may award grants to, and enter into contracts with, eligible entities to enhance the nursing workforce by initiating and maintaining nurse programs pursuant to subsection (b) or (c).

(b) Grants for Career Ladder Programs.—The Secretary may award grants to, and enter into contracts with, eligible entities for programs—

(1) to promote career advancement for individuals including licensed practical nurses, licensed vocational nurses, certified nurse assistants, home health aides, diploma degree or associate degree nurses, to become baccalaureate prepared registered nurses or advanced education nurses in order to meet the needs of the registered nurse workforce;

(2) to developing and implementing internships and residency programs in collaboration with an accredited school of nursing, as defined by section 801(2), to encourage mentoring and the development of specialties; or

(3) to assist individuals in obtaining education and training required to enter the nursing profession and advance within such profession.

(c) Enhancing Patient Care Delivery Systems.—

(1) Grants.—The Secretary may award grants to eligible entities to improve the retention of nurse staff and patient care programs that are directly related to nursing activities by enhancing collaboration and communication among nurses and other health care professionals, and by promoting nurse involvement in the organizational and clinical decision-making processes of a health care facility.

(2) Priority.—In making awards of grants under this subsection, the Secretary shall give preference to applicants that have not previously received an award under this subsection or section 831(c) as such section existed on the day before the date of enactment of this section.

(3) Continuation of an award.—The Secretary shall make continuation of any award under this subsection beyond the second year of such award contingent on the recipient of such award having demonstrated to the Secretary measurable and substantive improvement in nurse retention or patient care.

(d) Other Priority Areas.—The Secretary may award grants to, or enter into contracts with, eligible entities to address other areas that are of high priority to nurse retention, as determined by the Secretary.

(e) Reporting.—Each entity shall submit to the Congress before the end of each fiscal year a report on the grants awarded and the contracts entered into under this section. Each such report shall identify the overall number of such grants and contracts and provide an explanation of why each such grant or contract was not meet the priority need of the nursing workforce.

(f) Eligible Entity.—For purposes of this section, the term 'eligible entity' includes an accredited school of nursing, as defined by section 801(2), a health care facility, or a partnership of such a school and facility.

(g) Authorization of Appropriations.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2010 through 2014.

SEC. 5310. LOAN REPAYMENT AND SCHOLARSHIP PROGRAM.

(a) Loan Repayments and Scholarships.—Section 860a(3) of the Public Health Service Act (42 U.S.C. 297a(a)(3)) is amended by inserting before the semicolon the following: " or in an accredited school of nursing, as defined by section 861(2), as nurse faculty.

(b) Technical and Conforming Amendments.—Title VIII (42 U.S.C. 296 et seq.) is amended—

(1) by redesignating section 810 relating to public schools and direct support to nurses on the basis of sex as section 809 and moving such section so that it follows section 808;

(2) in sections 836, 838, 840, and 842, by striking the term the "this subpart" each place it appears and inserting "this part";

(3) in section 836(h), by striking the last sentence;

(4) in section 836, by redesignating subsection (l) as subsection (k);

(5) in section 839, by striking "839" and all that follows through "(a)" and inserting "839 (a)";

(6) in section 835(b), by striking "841" each place it appears and inserting "871";

(7) by redesignating section 871, moving part F to the end of the title, and redesignating such part as part I;

(8) in part I—

(A) by redesigning section 845 as section 851; and

(B) by redesigning part G as part F;

(9) in part H—

(A) by redesigning sections 851 and 852 as sections 861 and 862, respectively; and

(B) by redesigning part H as part G; and

(10) in part I—

(A) by redesigning section 855, as amended by section 5305, as section 865; and

(B) by redesigning part I as part H.

SEC. 5311. NURSE FACULTY LOAN PROGRAM.

(a) In General.—Section 844A of the Public Health Service Act (42 U.S.C. 297n-1) is amended—

(1) in subsection (a)—

(A) in the section heading, by striking "Establishment" and inserting "School of Nursing Student Loan Fund"; and

(B) by inserting "accredited" after "agreement with any";

(2) in subsection (c)—

(A) in paragraph (2), by striking "$30,000" and all that follows through the semicolon and inserting "$35,500, during fiscal years 2010 and 2011, such amounts shall be adjusted to provide for a cost-of-attendance increase for the yearly loan rate and the aggregate loan"; and

(B) in paragraph (3)(A), by inserting "accredited" after "faculty member in";

(3) in subsection (l), by striking "2003 through 2007" and inserting "2010 through 2014";

(b) Eligible Individual Student Loan Repayment.—Title VIII of the Public Health
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Service Act is amended by inserting after section 846A (42 U.S.C. 297n-1) the following:

"SEC. 877. ELIGIBLE INDIVIDUAL STUDENT LOAN REPAYMENTS.

(a) In General.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, may enter into an agreement with eligible individuals for the repayment of education loans, in accordance with this section, to increase the number of qualified nursing faculty.

(b) AGREEMENTS.—Each agreement entered into under this subsection shall require that the eligible individual shall serve as a full-time member of the faculty of an accredited school of nursing, for a period of one year.

(1) the date on which the individual receives a master's or doctorate nursing degree from an accredited school of nursing; or

(2) the date on which the individual enters into an agreement under this subsection.

(c) AGREEMENT PROVISIONS.—Agreements entered into pursuant to subsection (b) shall be entered into on such terms and conditions as the Secretary may determine, except that—

(1) not more than 10 months after the date on which the 6-year period described under subsection (b) begins, but in no case before the individual starts as a full-time member of the faculty of an accredited school of nursing the Secretary shall begin making payments, for and on behalf of that individual, on the outstanding principal of, and interest on, any loan of that individual obtained to pay for such degree; and

(2) for an individual who has completed a master's in nursing or equivalent degree in nursing—

(A) payments may not exceed $10,000 per calendar year; and

(B) total payments may not exceed $40,000 during the 2010 and 2011 fiscal years (after fiscal year 2011, such amounts shall be adjusted to provide for a cost-of-attendance increase for the yearly loan rate and the aggregate loan); and

(3) for an individual who has completed a doctorate or equivalent degree in nursing—

(A) payments may not exceed $20,000 per calendar year; and

(B) total payments may not exceed $80,000 during the 2010 and 2011 fiscal years (after fiscal year 2011, such amounts shall be adjusted to provide for a cost-of-attendance increase for the yearly loan rate and the aggregate loan).

(d) BREACH OF AGREEMENT.—

(1) In GENERAL.—In the case of any agreement made under subsection (b), the individual is liable to the Federal Government for the total amount paid by the Secretary under such agreement, and for interest on such amount at the maximum legal prevailing rate, if the individual fails to meet the agreement terms required under such subsection.

(2) WAIVER OR SUSPENSION OF LIABILITY.—In the case of an individual making an agreement for purposes of paragraph (1), the Secretary shall provide for the waiver or suspension of such paragraph if noncompliance by the individual with the agreement involved is impossible or would involve extreme hardship to the individual or if enforcement of the agreement with respect to the individual would be unconscionable.

(3) DATE CERTAIN FOR RECOVERY.—Subject to paragraph (2), any amount that the Federal Government is entitled to recover under paragraph (1) shall be paid to the United States not later than the expiration of the 3-year period beginning on the date the United States became liable for the failure of the individual to pay the amount.

(4) AVAILABILITY.—Amounts recovered under paragraph (1) shall be available to the Secretary for making loan repayments under this section and shall remain available for such purpose until expended.

SEC. 5312. AUTHORIZATION OF APPROPRIATIONS FOR PARTS B THROUGH D OF TITLE VIII.

Section 871 of the Public Health Service Act, as redesignated and moved by section 5310, is amended as follows:

"(d) AUTHORIZATION OF APPROPRIATIONS.—

"(1) IN GENERAL.—In the case of any agreement made under section 551, funding priority will be awarded to School of Nursing Student Loans that support doctoral nursing students or Individual Student Loan Repayment that support doctoral nursing students.

"(g) AUTHORIZATION OF APPROPRIATIONS.—

"There are authorized to be appropriated $30,000,000 for fiscal year 2010, and such sums as may be necessary for each of fiscal years 2011 through 2014.".

SEC. 5313. GRANTS TO PROMOTE THE COMMUNITY HEALTH WORKFORCE.

(a) IN GENERAL.—Part P 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. 389W. GRANTS TO PROMOTE POSITIVE HEALTH BEHAVIORS AND OUTCOMES.

(1) GRANTS AUTHORIZED.—The Director of the Centers for Disease Control and Prevention, in collaboration with the Secretary, shall award grants to eligible entities to promote positive health behaviors and outcomes for populations in medically underserved communities through the use of community health workers.

(2) USE OF FUNDS.—Grants awarded under subsection (a) shall be used to support community health workers—

(A) to educate, guide, and provide outreach regarding health problems prevalent in medically underserved communities, particularly racial and ethnic minority populations; and

(B) to educate and provide guidance regarding effective strategies to promote positive health behaviors and discourage risky health behaviors.

(3) To evaluate and provide outreach regarding enrollment in health insurance including the Children's Health Insurance Program under title XXI of the Social Security Act, Medicare under title XVIII of such Act and Medicaid under title XIX of such Act;

(4) to identify, educate, refer, and enroll underserved populations to appropriate healthcare agencies and community-based programs and organizations in order to increase access to quality healthcare services and to eliminate duplicative care; or

(5) to evaluate and provide home visitation services regarding maternal health and prenatal care.

(c) APPLICATION.—Each eligible entity that desires to receive a grant under this section shall submit an application to the Secretary, at such time, in such manner, and accompanied by such information as the Secretary may require.

(d) PRIORITY.—In awarding grants under subsection (a), the Secretary shall give priority to applicants that—

(1) propose to target geographic areas—

(A) with a high percentage of residents who are eligible for insurance but are uninsured or underinsured;

(B) with a high percentage of residents who suffer from chronic diseases; or

(C) with a high infant mortality rate; and

(2) have experience in providing health or health-related social services to individuals who are underserved with respect to such services and

(3) have documented community activity and experience with community health workers.

(4) COLLABORATION WITH ACADEMIC INSTITUTIONS AND THE ONE-STOP DELIVERY SYSTEM.—The Secretary shall encourage community health worker programs receiving funds under this section to collaborate with academic institutions and one-stop delivery systems under section 134(c) of the Workforce Investment Act of 1998. Nothing in this section shall be construed to require such collaboration.

(5) EVIDENCE-BASED INTERVENTIONS.—The Secretary shall encourage community health worker programs receiving funding under this section to implement a process or an outcome-based payment system that rewards community health worker programs receiving underserved populations with the most appropriate services at the most appropriate time. Nothing in this section shall be construed to require such a payment.

(g) QUALITY ASSURANCE AND COST EFFECTIVENESS.—The Secretary shall establish guidelines for ensuring the quality and effectiveness of the training and supervision of community health workers under the programs funded under this section and for assuring the cost-effectiveness of such programs.

(b) MONITORING.—The Secretary shall monitor community health worker programs identified in approved applications under this section and shall determine whether such programs are in compliance with the guidelines established under subsection (g).

(2) TECHNICAL ASSISTANCE.—The Secretary may provide technical assistance to community health worker programs identified in approved applications under this section with respect to planning, developing, and operating programs under the grant.

(3) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated, for fiscal year 2010, and such sums as may be necessary for each of fiscal years 2011 through 2014, to carry out this section such sums as may be necessary for each of fiscal years 2011 through 2014.

(k) DEFINITIONS.—In this section:

(1) COMMUNITY HEALTH WORKER.—The term 'community health worker', as defined by the Department of Labor as Standard Occupational Classification (21–1994) means an individual who promotes health or nutrition within the community in which the individual resides;

(2) BY PROVIDING GUIDANCE AND SOCIAL ASSESSMENT TO THE COMMUNITY POPULATION;

(A) by providing culturally and linguistically appropriate services at the most appropriate outcome-based payment system that rewards community health worker programs receiving underserved populations with the most appropriate services at the most appropriate time; and

(3) BY PROVIDING GUIDANCE AND SOCIAL ASSESSMENT TO THE INDIVIDUAL RESIDENTS;

(A) by providing culturally and linguistically appropriate health or nutrition education;

(B) by advocating for individual and community health;

(F) by providing referral and follow-up services or otherwise coordinating care; and

(G) by proactively identifying and enrolling individuals as appropriate.
SEC. 5315. UNITED STATES PUBLIC HEALTH SCIENCES TRACK.

Title II of the Public Health Service Act (42 U.S.C. 202 et seq.) is amended by adding at the end the following:

"PART D—UNITED STATES PUBLIC HEALTH SCIENCES TRACK

SEC. 271. ESTABLISHMENT.

(a) UNITED STATES PUBLIC HEALTH SCIENCES TRACK—

(1) IN GENERAL.—There is hereby authorized to be established a United States Public Health Sciences Track referred to in this part as the Track, which shall be selected by the Secretary, with authority to grant appropriate advanced degrees in a manner that uniquely emphasizes team-based service, interdisciplinary health-related education, and emergency preparedness and response. It shall be so organized as to graduate not less than—

(A) 150 medical students annually, 10 of whom shall be awarded scholarships to the Uniformed Services University of Health Sciences;

(B) 10 dental students annually;

(C) 250 nursing students annually;

(D) 100 public health students annually;

(E) 100 behavioral and mental health professional students annually;

(F) 100 postdoctoral, postgraduate, and other professional students annually; and

(G) 50 pharmacy students annually.

(2) LOCATIONS.—The Track shall be located at educational and affiliated health professions education training programs at academic health centers located in regions of the United States determined appropriate by the Secretary, in consultation with the National Health Care Workforce Commission established in section 5105 of the Patient Protection and Affordable Care Act.

(b) NUMBER OF GRADUATES.—Except as provided in subsection (a), the number of persons to be graduated from the Track shall be prescribed by the Secretary. In so prescribing the number of persons to be graduated from the Track, the Secretary shall Institute actions necessary to ensure the maximum number of first-year enrollees in the Track consistent with the academic capacity of the affiliated sites and the needs of the United States for medical, dental, and nursing personnel.

(c) DEVELOPMENT.—The development of the Track may be by such phases as the Secretary may prescribe subject to the requirements of subsection (a).

(d) INTEGRATED LONGITUDINAL PLAN.—The Surgeon General shall develop an integrated longitudinal plan for health professions continuing education throughout the continuum of health-related education, training, and practice. Training under such plan shall emphasize the importance of collaboration and care coordination skills. Experience with deployment of emergency response teams shall be included during the clinical experiences.

(e) FACULTY DEVELOPMENT.—The Surgeon General shall develop faculty development programs and curricula in decentralized venues of health care delivery urban, tertiary, and inpatient venues.

SEC. 272. ADMINISTRATION.

(a) IN GENERAL.—The business of the Track shall be conducted by the Surgeon General with funds appropriated for and provided by the Department of Health and Human Services. The National Health Care Workforce Commission shall assist the Surgeon General in an advisory capacity.

(b) FACULTY.—

(1) IN GENERAL.—The Surgeon General, after considering the recommendations of the National Health Care Workforce Commission, shall obtain the services of such professors, instructors, and administrative and other employees as may be necessary to operate the Track, but utilize when possible, existing affiliated health professions training institutions. Faculty and staff shall be employed under salary schedules and granted retirement and other related benefits prescribed by the Secretary so that the employees are accredited faculty on a comparable basis with the employees of fully accredited schools of the health professions within the United States.

(2) TITLES.—The Surgeon General may confer academic titles, as appropriate, upon the members of the faculty.

SEC. 273. NONAPPLICATION OF PROVISIONS.—The limitations in section 5373 of title 5, United States Code, shall not apply to the authority of the Surgeon General under paragraph (1) to prescribe salary schedules and other related benefits.

(c) AGREEMENTS.—The Surgeon General may negotiate agreements with agencies of the Federal Government to utilize on a reimbursable basis appropriate existing Federal medical resources located in the United States. Such agreements may include provisions for educational services provided students participating in Department of Health and Human Services educational programs.

(d) PROGRAMS.—The Surgeon General may establish the following educational programs for Track students:

(1) Postdoctoral, postgraduate, and technological programs.

(2) A cooperative program for medical, dental, physician assistant, pharmacy, behavioral, and mental health, public health, and nursing students.

(3) Other programs that the Surgeon General determines necessary in order to operate the Track in a cost-effective manner.

(e) CONTINUING MEDICAL EDUCATION.—The Surgeon General shall establish programs in continuing medical education in a manner that affects the health professions to the end that high standards of health care may be maintained within the United States.

SEC. 5316. UNITED STATES PUBLIC HEALTH SERVICE ACT (42 U.S.C. 202 et seq.), as amended by section 5206, is further amended by adding at the end the following:

"SEC. 778. FELLOWSHIP TRAINING IN APPLIED PUBLIC HEALTH EPIDEMIOLOGY, PUBLIC HEALTH LABORATORY SCIENCE, PUBLIC HEALTH INFORMATICS, AND EXPANSION OF THE EPIDEMIC INTELLIGENCE SERVICE.

(a) IN GENERAL.—The Secretary may carry out activities to address documented workforce needs of States and local public health departments in the critical areas of applied public health epidemiology and public health laboratory science and informatics and may expand the Epidemic Intelligence Service.

(b) SPECIFIC USES.—In carrying out subsection (a), the Secretary shall provide for the expansion of existing fellowship programs operated through the Centers for Disease Control and Prevention in a manner that is designed to alleviate shortages of the type described in subsection (a).

(c) OMNIBUS.—The Secretary may provide for the expansion of other applied epidemiology training programs that meet objectives similar to the objectives of the programs described in subsection (b).

(d) WORK OBLIGATION.—Participation in fellowship training programs under this section shall be deemed to be service for purposes of satisfying work obligations stipulated in contracts under section 338(b).

(e) GENERAL SUPPORT.—Amounts may be used from grants awarded under this section to expand the Public Health Informatics Fellowship Program at the Centers for Disease Control and Prevention to better support all public health systems at all levels of government.

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $39,500,000 for each of fiscal years 2010 through 2013, of which—

(1) $5,000,000 shall be made available in each such fiscal year for epidemiology fellowship training program activities under subsection (b); and

(2) $5,000,000 shall be made available in each such fiscal year for laboratory fellowship training programs under subsection (b).

(g) TECHNICAL ASSISTANCE.—The Secretary shall be made available for expanding the Epidemic Intelligence Service under subsection (a)."

"(2) COMMUNITY SETTING.—The term ‘community setting’ means a home or a community organization located in the neighborhood in which a participant in the program under subsection (a) resides.

"(3) ELIGIBLE ENTITY.—The term ‘eligible entity’ means a public or nonprofit private entity (including a State or public subdivision of a State) that has as one of its principal activities the provision of a health care delivery system. A free health clinic, a hospital, or a Federally qualified health center (as defined in section 1861(aa) of the Social Security Act), or a community organization, is an eligible entity.

"(4) MEDICALLY UNDERSERVED COMMUNITY.—The term ‘medically underserved community’ means a community identified by a State—

(A) that has a substantial number of individuals who are members of a medically underserved population, as defined by section 330(b)(3); and

(B) a significant portion of which is a health professional shortage area as designated under section 332.

SEC. 5314. FELLOWSHIP TRAINING IN PUBLIC HEALTH.

Part E of title VII of the Public Health Service Act (42 U.S.C. 294n et seq.), as amended by section 5306, is further amended by adding at the end the following:

"SEC. 778. FELLOWSHIP TRAINING IN APPLIED PUBLIC HEALTH EPIDEMIOLOGY, PUBLIC HEALTH LABORATORY SCIENCE, PUBLIC HEALTH INFORMATICS, AND EXPANSION OF THE EPIDEMIC INTELLIGENCE SERVICE.

(a) IN GENERAL.—The Secretary may carry out activities to address documented workforce needs of States and local public health departments in the critical areas of applied public health epidemiology and public health laboratory science and informatics and may expand the Epidemic Intelligence Service.

(b) SPECIFIC USES.—In carrying out subsection (a), the Secretary shall provide for the expansion of existing fellowship programs operated through the Centers for Disease Control and Prevention in a manner that is designed to alleviate shortages of the type described in subsection (a).

(c) OMNIBUS.—The Secretary may provide for the expansion of other applied epidemiology training programs that meet objectives similar to the objectives of the programs described in subsection (b).

(d) WORK OBLIGATION.—Participation in fellowship training programs under this section shall be deemed to be service for purposes of satisfying work obligations stipulated in contracts under section 338(b).

(e) GENERAL SUPPORT.—Amounts may be used from grants awarded under this section to expand the Public Health Informatics Fellowship Program at the Centers for Disease Control and Prevention to better support all public health systems at all levels of government.

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $39,500,000 for each of fiscal years 2010 through 2013, of which—

(1) $5,000,000 shall be made available in each such fiscal year for epidemiology fellowship training program activities under subsection (b); and

(2) $5,000,000 shall be made available in each such fiscal year for laboratory fellowship training programs under subsection (b).

(g) TECHNICAL ASSISTANCE.—The Secretary shall be made available for expanding the Epidemic Intelligence Service under subsection (a)."
to make outlays in advance of the enactment of budget authority for such outlays.

"(3) SCIENTISTS.—Scientists or other medical, dental, or nursing personnel utilized by the Surgeon General may be appointed to any position within the Track and may be permitted to perform such duties within the Track as the Surgeon General determines.

"(4) VOLUNTEER SERVICES.—A person who provides voluntary services under the authority of subparagraph (E) of paragraph (1) shall be considered to be an employee of the Federal Government for the purposes of chapter 81 of title 5, relating to compensation for work-related injuries, and to be an employee of the Federal Government for the purposes of chapter 171 of title 28, relating to tort claims. Such a person who is not otherwise employed by the Federal Government shall not be considered to be a Federal employee for any other purpose by reason of the provision of such services.

SEC. 273. STUDENTS; SELECTION; OBLIGATION.

(a) STUDENT SELECTION.—

(1) IN GENERAL.—Medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, and nursing students at the Track shall be selected under procedures determined by the Surgeon General. In so prescribing, the Surgeon General shall consider the recommendations of the National Health Care Workforce Commission.

(2) PRIORITY.—In developing admissions procedures under paragraph (1), the Surgeon General shall ensure that such procedures give priority to applicants from rural communities and underrepresented minority groups.

(b) CONTRACT AND SERVICE OBLIGATION.—

(1) CONTRACT.—Upon being admitted to the Track, each medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, or nursing student shall enter into a written contract with the Surgeon General that shall contain—

(A) an agreement under which—

(i) subject to subparagraph (B), the student agrees—

(II) for each school year during which such individual is enrolled upon funds being appropriated to carry out this part;

(ii) subject to subparagraph (B), the student agrees—

(II) for each school year during which such individual is enrolled upon funds being appropriated to carry out this part;

(iii) not less than $6,000,000 for grants under subsection (i) for a fiscal year are $24,000,000 or less—

(II) 40 percent of such amount for grants under subsection (i) for a fiscal year exceed $30,000,000—

(ii) not less than $6,000,000 for grants under subsection (i) for a fiscal year exceed $24,000,000 but are less than $30,000,000—

(iii) not less than $6,000,000 for grants under subsection (i) for a fiscal year exceed $24,000,000 but are less than $40,000,000—

(c) FUNDING IN EXCESS OF $30,000,000.—If amounts appropriated under subsection (i) for a fiscal year exceed $30,000,000 but are less than $40,000,000, the Secretary shall make available—

(ii) 20 percent of such excess amount shall be made available for grants under subsection (a) to health professions schools that meet the conditions described in paragraph (3) or (4) of subsection (c) (including meeting the conditions under subsection (e));

(2) TUITION AND STUDENT STIPEND.—

(A) STUDENT SELECTION.—The Surgeon General, based on the recommendations of the National Health Care Workforce Commission, shall establish Federal tuition remission rates to be used by the Track to provide reimbursement to affiliated and other participating health professions institutions for the cost of educational services provided by such institutions to Track students. The agreement entered into by such participating institutions under paragraph (1)(A)(i) shall contain an agreement to accept payment in full the established remission rate under this subparagraph.

(B) STUDENT DROPPED FROM TRACK IN AFFILIATE SCHOOL.—A student who is dropped from the Track in an affiliated school for deficiency in conduct or studies, or for other reasons, shall be liable to the Track for all tuition and stipend support provided to the student.

SEC. 274. FUNDING.

Beginning with fiscal year 2010, the Secretary shall transfer from the Public Health and Social Services Emergency Fund such sums as may be necessary to carry out this part.

Subtitle E—Supporting the Existing Health Care Workforce

SEC. 5401. CENTERS OF EXCELLENCE.

(a) AUTHORITY.—The Secretary of Health and Human Services (hereinafter in this section referred to as the "Secretary") shall create centers of excellence in health professions educational training, the purposes of which shall be to train medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, and nursing students for some training in the military (including training in public health emergencies, natural disasters, bio-terrorism events, and other emergencies.

(b) STUDENT DROPPED FROM TRACK IN AFFILIATE SCHOOL.—A medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, or nursing student, who is under regulations prescribed by the Surgeon General, is dropped from the Track in an affiliated school for deficiency in conduct or studies, or for other reasons, shall be liable to the Track for all tuition and stipend support provided to the student.
schools that meet the conditions described in subsection (c)(5); and

‘‘(iv) after grants are made with funds under clauses (i) through (iii), any remaining unexpended amounts from that fiscal year shall be available for use under subsection (a) to health professions schools that meet the conditions described in paragraph (5) of subsection (c);’’.

‘‘(C) Development of area health education centers.—For purposes of subsection (a)(1), the term ‘eligible entity’ means a school of medicine or osteopathic medicine, a school of pharmacy, or an area health education center program to which amounts have been awarded under this section, and includes any entity that is prepared to deliver high-quality care, with an emphasis on primary care, in underserved areas and for health disparity populations, in collaboration with other Federal and State health care workforce development programs, the State workforce agency, local workforce investment boards, and, in health care safety net sites.

‘‘(D) Prepare individuals to more effectively provide health services to underserved areas and populations through field placements or preceptorships in conjunction with community-based organizations, accredited primary care residency training programs, Federally qualified health centers, rural health clinics, public health departments, or other appropriate facilities.

‘‘(E) Conduct and participate in inter-disciplinary training that involves physi- cians, physician assistants, nurse practi- tioners, nurse midwives, dentists, psychologists, other behavioral or mental health workers, public and allied health professionals, or other health professionals, as practicable.

‘‘(F) Deliver or facilitate continuing edu- cation and information dissemination programs for health care professionals, with an emphasis on individuals providing care in underserved areas and for health disparity populations.

‘‘(G) Propose and implement effective program and outcomes measurement and evaluation strategies.

‘‘(H) Establish a youth public health program to expose and recruit high school stu- dents into health careers, with a focus on ca- reers in public health.

‘‘(2) Innovative opportunities.—An eligible entity may use amounts awarded under a grant under subsection (a)(1) or subsection (a)(2) to carry out any of the following activities:

‘‘(A) Develop and implement innovative curricula in collaboration with community- based participatory research with academic health centers, and facilitate rapid flow and dis- semination of evidence-based health care in- formation, research results, and best prac- tices to improve quality, efficiency, and ef- fectiveness of health care and health care systems within community settings.

‘‘(B) Develop and implement other strate- gies or programs that address identified workforce needs and increase and enhance the health care workforce in the area served by the area health education center program.

‘‘(C) Establish and implement the appropriate strategies and activities to foster and maintain a diverse health care workforce that is prepared to deliver high-quality care, with an emphasis on primary care, in underserved areas and for health disparity populations.

‘‘(D) Develop and implement strategies to foster and provide community-based training and education to individuals seeking careers in health professions within underserved areas and populations, in collaboration with other Federal and State health care workforce development programs, the State workforce agency, local workforce investment boards, and, in health care safety net sites.

‘‘(E) Evaluate the effectiveness of health care workforce development programs, the State workforce agency, local workforce investment boards, and, in health care safety net sites.

‘‘(F) Propose and implement effective pro- gram and outcomes measurement and eval- uation strategies.

‘‘(G) Establish a youth public health program to expose and recruit high school stu- dents into health careers, with a focus on ca- reers in public health.

‘‘(2) Innovative opportunities.—An eligible entity may use amounts awarded under a grant under subsection (a)(1) or subsection (a)(2) to carry out any of the following activities:

‘‘(A) Develop and implement innovative curricula in collaboration with community- based participatory research with academic health centers, and facilitate rapid flow and dis- semination of evidence-based health care in- formation, research results, and best prac- tices to improve quality, efficiency, and ef- fectiveness of health care and health care systems within community settings.

‘‘(B) Develop and implement other strate- gies or programs that address identified workforce needs and increase and enhance the health care workforce in the area served by the area health education center program.

‘‘(C) Establish and implement the appropriate strategies and activities to foster and maintain a diverse health care workforce that is prepared to deliver high-quality care, with an emphasis on primary care, in underserved areas and for health disparity populations.

‘‘(D) Develop and implement strategies to foster and provide community-based training and education to individuals seeking careers in health professions within underserved areas and populations, in collaboration with other Federal and State health care workforce development programs, the State workforce agency, local workforce investment boards, and, in health care safety net sites.

‘‘(E) Evaluate the effectiveness of health care workforce development programs, the State workforce agency, local workforce investment boards, and, in health care safety net sites.

‘‘(F) Propose and implement effective pro- gram and outcomes measurement and eval- uation strategies.

‘‘(G) Establish a youth public health program to expose and recruit high school stu- dents into health careers, with a focus on ca- reers in public health.

‘‘(2) Innovative opportunities.—An eligible entity may use amounts awarded under a grant under subsection (a)(1) or subsection (a)(2) to carry out any of the following activities:

‘‘(A) Develop and implement innovative curricula in collaboration with community- based participatory research with academic health centers, and facilitate rapid flow and dis- semination of evidence-based health care in- formation, research results, and best prac- tices to improve quality, efficiency, and ef- fectiveness of health care and health care systems within community settings.

‘‘(B) Develop and implement other strate- gies or programs that address identified workforce needs and increase and enhance the health care workforce in the area served by the area health education center program.

‘‘(C) Establish and implement the appropriate strategies and activities to foster and maintain a diverse health care workforce that is prepared to deliver high-quality care, with an emphasis on primary care, in underserved areas and for health disparity populations.

‘‘(D) Develop and implement strategies to foster and provide community-based training and education to individuals seeking careers in health professions within underserved areas and populations, in collaboration with other Federal and State health care workforce development programs, the State workforce agency, local workforce investment boards, and, in health care safety net sites.

‘‘(E) Evaluate the effectiveness of health care workforce development programs, the State workforce agency, local workforce investment boards, and, in health care safety net sites.

‘‘(F) Propose and implement effective pro- gram and outcomes measurement and eval- uation strategies.

‘‘(G) Establish a youth public health program to expose and recruit high school stu- dents into health careers, with a focus on ca- reers in public health.

‘‘(2) Innovative opportunities.—An eligible entity may use amounts awarded under a grant under subsection (a)(1) or subsection (a)(2) to carry out any of the following activities:

‘‘(A) Develop and implement innovative curricula in collaboration with community- based participatory research with academic health centers, and facilitate rapid flow and dis- semination of evidence-based health care in- formation, research results, and best prac- tices to improve quality, efficiency, and ef- fectiveness of health care and health care systems within community settings.

‘‘(B) Develop and implement other strate- gies or programs that address identified workforce needs and increase and enhance the health care workforce in the area served by the area health education center program.

‘‘(C) Establish and implement the appropriate strategies and activities to foster and maintain a diverse health care workforce that is prepared to deliver high-quality care, with an emphasis on primary care, in underserved areas and for health disparity populations.

‘‘(D) Develop and implement strategies to foster and provide community-based training and education to individuals seeking careers in health professions within underserved areas and populations, in collaboration with other Federal and State health care workforce development programs, the State workforce agency, local workforce investment boards, and, in health care safety net sites.
entity that receives an award under this section is a nursing school or its parent institution, the Secretary shall alternatively ensure that—

(1) the nursing school conducts at least 10 percent of clinical education required for nursing students in community settings that are remote from the primary teaching facility of the nursing school in training under the area health education center program area.

(2) An entity receiving funds under subsection (a) may distribute the funds to a center that is eligible to receive funding under subsection (a)(1).

(3) AREA HEALTH EDUCATION CENTER.—The Secretary shall ensure that each area health education center program includes at least 1 area health education center, and that each such center—

(A) is a public or private organization whose structure, governance, and operation is independent from the awardee and the parent institution of the awardee;

(B) may involve a school of medicine or osteopathic medicine, the parent institution of such a school, or a branch campus or other subunit of a school of medicine or osteopathic medicine, a public, private, or parastate institution, or a consortium of such entities;

(C) designates an underserved area or population to be served by the center which is in a location removed from the main location of the teaching facilities of the schools participating in the program with such center and does not duplicate, in whole or in part, the geographic area or population served by any other center;

(D) fosters networking and collaboration among communities and between academic health centers and community-based centers;

(E) serves communities with a demonstrated need of health professionals in partnership with academic medical centers;

(F) addresses the health care workforce needs of the communities served in coordination with the public workforce investment system; and

(G) has a community-based governing or advisory board that reflects the diversity of the communities involved.

(e) MATCHING FUNDS.—With respect to the costs of operating a program through a grant under this section, to be eligible for financial assistance, an area health education center must make available (directly or through contributions from State, county or municipal governments, or the private sector) recurring non-Federal contributions in cash or in kind, toward such costs in an amount that is equal to not less than 50 percent of such costs.

(f) LIMITATION.—Not less than 75 percent of the total amount provided to an area health education center program under subsection (a)(1) or (a)(2) shall be allocated to the area health education centers participating in the program under this section. To provide needed flexibility to newly funded area health education center programs, the Secretary may waive the requirement in the sentence for the first 2 years of a new area health education center program funded under this section.

(g) AWARD.—An award to an entity under this section shall be not less than $250,000 annually per area health education center included in the program involved. If amounts appropriated to carry out this section are not sufficient to comply with the preceding sentence and the per-center amount provided for in such sentence as necessary, provided the distribution established in subsection (j)(2) is maintained.

(1) IN GENERAL.—Except as provided in paragraph (2), the period during which payments may be made under an award under subsection (a) shall not exceed 6 years.

(2) EXCLUSION.—The periods described in paragraph (1) shall not apply to programs receiving point of service maintenance and enhancement awards under subsection (a)(2) to maintain existing centers and activities.

(1) INAPPLICABILITY OF PROVISION.—Notwithstanding any other provision of this title, section 792(a) shall not apply to an area health education center funded under this section.

(2) AUTHORIZATION OF APPROPRIATIONS.—(A) In general.—The area health education center program established in subsection (j)(2) is maintained.

(3) CARRYOVER FUNDS.—An entity that receives an award under this section may carry over funds from 1 fiscal year to another without obtaining approval from the Secretary. In no case may any funds be carried over pursuant to the preceding sentence for more than 3 years.

(k) SENSE OF CONGRESS.—It is the sense of the Congress that every State have an area health education center program in effect under this section.

(l) CARRIERS OF FUNDS.—An entity that receives an award under this section may carry over funds from 1 fiscal year to another without obtaining approval from the Secretary.

(2) REQUIREMENTS.—Of the amounts appropriated for a fiscal year under paragraph (1)—

(A) not more than 35 percent shall be used for awards under subsection (a)(1);

(B) not less than 60 percent shall be used for awards under subsection (a)(2);

(C) not more than 1 percent shall be used for grants and contracts to implement outcomes evaluation for the area health education centers; and

(D) not more than 4 percent shall be used for grants and contracts to provide technical assistance to entities receiving awards under this section.

(3) CARRIERS OF FUNDS.—An entity that receives an award under this section may carry over funds from 1 fiscal year to another without obtaining approval from the Secretary.

(2) REQUIREMENTS.—An entity that receives an award under this section may carry over funds from 1 fiscal year to another without obtaining approval from the Secretary. In no case may any funds be carried over pursuant to the preceding sentence for more than 3 years.

(3) CARRIERS OF FUNDS.—An entity that receives an award under this section may carry over funds from 1 fiscal year to another without obtaining approval from the Secretary.

(2) REQUIREMENTS.—An entity that receives an award under this section may carry over funds from 1 fiscal year to another without obtaining approval from the Secretary. In no case may any funds be carried over pursuant to the preceding sentence for more than 3 years.

(3) CARRIERS OF FUNDS.—An entity that receives an award under this section may carry over funds from 1 fiscal year to another without obtaining approval from the Secretary.

(2) REQUIREMENTS.—An entity that receives an award under this section may carry over funds from 1 fiscal year to another without obtaining approval from the Secretary. In no case may any funds be carried over pursuant to the preceding sentence for more than 3 years.

(3) CARRIERS OF FUNDS.—An entity that receives an award under this section may carry over funds from 1 fiscal year to another without obtaining approval from the Secretary.

(2) REQUIREMENTS.—An entity that receives an award under this section may carry over funds from 1 fiscal year to another without obtaining approval from the Secretary. In no case may any funds be carried over pursuant to the preceding sentence for more than 3 years.
of the Patient Protection and Affordable Care Act;
(ii) collect data and provision of primary care provider feedback from standardized measures of outcomes to aid in continuous performance improvement;
(iii) collaborate with local health departments, community health centers, tribes and tribal organizations, and other primary care agencies to identify community health priorities and local health workforce needs, and participate in community-based efforts to address outcomes; and
(iv) develop measures to monitor the impact of the program on the health, strengthen the local primary care workforce, and eliminate health disparities;
(C) Coordinate functions with quality improvement organizations and area health education centers if such entities are members of the Hub described in subsection (b)(2)(A);
(D) Administer grant funds to county- or local-level Primary Care Extension Agencies that serve a catchment area, as determined by the State; and
(E) develop plans for funding direct patient care.
(iv) REQUIREMENTS ON THE SECRETARY.—In carrying out this section, the Secretary shall consult with other Federal agencies with demonstrated experience and expertise in health care and preventive medicine, such as the Centers for Disease Control and Prevention, the Substance Abuse and Mental Health Administration, the Health Resources and Services Administration, the National Institutes of Health, the Office of the National Coordinator for Health Information Technology, the Indian Health Service, the Agricultural Cooperative Extension Service of the Department of Agriculture, and other entities as the Secretary determines appropriate.
(f) AUTHORIZATION OF APPROPRIATIONS.—To award grants as provided in subsection (d), there are appropriated $120,000,000 for each of fiscal years 2011 and 2012, and such sums as may be necessary to carry out this section for each of fiscal years 2013 through 2023.

Subtitle F—Strengthening Primary Care and Other Workforce Improvements

SEC. 5501. EXPANDING ACCESS TO PRIMARY CARE SERVICES AND GENERAL SURGICAL PROCEDURES

(a) Incentive Payment Program for Primary Care Services.—

(1) In general.—Section 1833 of the Social Security Act (42 U.S.C. 1395l) is amended by adding at the end the following new subsection:

‘‘(i) who—

(A) is a physician (as described in section 1861(v)(1)) who has a primary specialty designation of family medicine, internal medicine, geriatrics, or psychiatric medicine; or

(B) is a nurse practitioner, clinical nurse specialist, or physician assistant (as those terms are defined in section 1861(aa)(5)); and

(ii) for whom primary care services accounted at least 90 percent of the allowed charges under this part for such physician or practitioner in a prior period as determined appropriate by the Secretary.’’.

(b) Incentive Payment Program for Major Surgical Procedures Fulfilled in Health Professional Shortage Areas.—

(1) In general.—Section 1833 of the Social Security Act (42 U.S.C. 1395l), as amended by section (a)(2)(B) of the Social Security Act (42 U.S.C. 1395m(c)(2)(B)), is amended by adding at the end the following new subsection:

‘‘(x) INCENTIVE PAYMENTS FOR PRIMARY CARE SERVICES.—

‘‘(1) In general.—In the case of primary care services furnished on or after January 1, 2011, and before January 1, 2016, by a primary care practitioner, in addition to the amount of payment that would otherwise be made for such services under this part, there shall be paid (on a monthly or quarterly basis) an amount equal to 10 percent of the payment amount for the service under this part.

‘‘(2) Definitions.—In this subsection:

(A) PRIMARY CARE PRACTITIONER.—The term ‘primary care practitioner’ means an individual—

(i) who—

(I) is a physician (as described in section 1861(v)(1)) who has a primary specialty designation of family medicine, internal medicine, geriatrics, or psychiatric medicine; or

(II) is a nurse practitioner, clinical nurse specialist, or physician assistant (as those terms are defined in section 1861(aa)(5)); and

(ii) for whom primary care services accounted at least 90 percent of the allowed charges under this part for such physician or practitioner in a prior period as determined appropriate by the Secretary.

(B) INCENTIVE PAYMENTS.—The term ‘incentive payments’ means services identified, as of January 1, 2009, by the following HCPCS codes (and as subsequently modified by the Secretary):

(i) 99201 through 99215.

(ii) 99204 through 99340.

(iii) 99211 through 99350.

(iii) COORDINATION WITH OTHER PAYMENTS.—The amount of the additional payment for a service under this subsection and subsection (m) shall be determined without regard to any additional payment for the service under subsection (m) and this subsection, respectively.

(2) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise, respecting the identification of primary care practitioners under this subsection.

CONFORMING AMENDMENT.—Section 1833(g)(2)(B) of the Social Security Act (42 U.S.C. 1395m(g)(2)(B)) is amended by adding at the end the following new sentence: ‘‘Section 1833(g)(2)(B) shall not be used in determining the amounts that would otherwise be paid pursuant to the preceding sentence.’’.

(b) Incentive Payment Program for Major Surgical Procedures Fulfilled in Health Professional Shortage Areas.—

(1) In general.—Section 1833 of the Social Security Act (42 U.S.C. 1395l), as amended by section (a)(2)(B) of the Social Security Act (42 U.S.C. 1395m(c)(2)(B)), is amended by adding at the end the following new subsection:

‘‘(x) INCENTIVE PAYMENTS FOR PRIMARY CARE SERVICES.—

‘‘(1) In general.—Section 1833 of the Social Security Act (42 U.S.C. 1395l) is amended by adding at the end the following new subsection:

‘‘(x) INCENTIVE PAYMENTS FOR PRIMARY CARE SERVICES.—

‘‘(1) In general.—In the case of major surgical procedures furnished on or after January 1, 2011, and before January 1, 2016, by a general surgeon in an area that is designated as a health professional shortage area as identified by the Secretary prior to the beginning of the year involved, in addition to the amount of payment that would otherwise be made for such services under this part, there shall be paid (on a monthly or quarterly basis) an amount equal to 10 percent of the payment amount for the service under this part.

(C) Definitions.—In this subsection:

(A) General surgeon.—In this subsection, the term ‘general surgeon’ means a
physician (as described in section 1861(r)(1)) who has designated CMS specialty code 02—General Surgery as their primary specialty code in the physician’s enrollment under section 1861(b)(3).

(b) Major surgical procedures.—The term ‘‘major surgical procedures’’ means physicians’ services which are surgical procedures which require a midweek or Sunday illegally period to be used for payment under the fee schedule under section 1848(b).

(c) Coordination with other payments.—The amount of the additional payment for a service under this subsection and subsection (m) shall be determined without regard to any additional payment for the service under subsection (m) and this subsection, respectively.

(d) Application.—The provisions of paragraph (2) and (4) of subsection (m) shall apply to the determination of additional payments under this subsection in the same manner as such provisions apply to the determination of additional payments under subsection (m).

(2) Conforming amendment.—Section 1834(g)(2)(B) of the Social Security Act (42 U.S.C. 1395w–4(g)(2)(B)) as amended by section (a)(2), is amended by striking ‘‘Section 1833(x)’’ and inserting ‘‘Subsections (x) and (y) of section 1833’’ in the last sentence.

(3) Secretary’s advisory council.—Subsection (a)(3)(A)(3) of the Social Security Act (42 U.S.C. 1395w–4(c)(3)(A)(3)) is amended by adding at the end the following new clause: ‘‘(ii) such care or care furnished on an incentive payments.—Fifty percent of the additional expenditures under this part attributable to subsections (x) and (y) of section 1833 for a year (as estimated by the Secretary) shall be taken into account in applying clause (ii) for 2011 and subsequent years. In lieu of applying the budget-neutrality adjustment required under clause (ii) to relative units to account for such costs for the year, the Secretary shall apply such budget-neutrality adjustments to the conversion factor otherwise determined for the year. For 2011 and subsequent years, the Secretary shall increase the incentive payment otherwise applicable under section 1835(m) by a percent estimated to be equal to the additional expenditures estimated under the first sentence of this clause for such year that is applicable to physicians who primarily provide services in areas designated under section 332(a)(1)(A) of the Public Health Service Act as health professional shortage areas.”

SEC. 5502. Medicare-funded qualified health center improvements.

(a) Expansion of Medicare-covered preventive services at federally qualified health centers.—

(1) in general.—Section 1861(k)(6) of the Social Security Act (42 U.S.C. 1395w–4(k)(6)) is amended by—

(A) striking ‘‘such provision’’ and inserting ‘‘this section’’ and

(B) inserting the following new subparagraphs:—

(I) the Secretary shall—

(i) in paragraph (7) and (8) ;

(ii) in paragraph (7) ;

(iii) in paragraph (7) ;

(iv) in paragraph (7) ;

(v) in paragraph (7) ;

(vi) in paragraph (7) ;

(vii) in paragraph (7) ;

(viii) in paragraph (7) ;

(ix) in paragraph (7) ;

(x) in paragraph (7) ;

(xi) in paragraph (7) ;

(xii) in paragraph (7) ;

(xiii) in paragraph (7) ;

(xiv) in paragraph (7) ;

(xv) in paragraph (7) ;

(xvi) in paragraph (7) ;

(xvii) in paragraph (7) ;

(xviii) in paragraph (7) ;

(xix) in paragraph (7) ;

(xx) in paragraph (7) ;

(2) Effective date.—The amendment made by paragraph (1) shall apply to services furnished on or after January 1, 2011.

(b) Prospective payment system for federally qualified health centers.—

Section 1834 of the Social Security Act (42 U.S.C. 1395w–4) is amended by adding at the end the following new subsection:

‘‘(ii) Development and implementation of prospective payment system.—

‘‘(I) In general.—The Secretary shall develop a prospective payment system for payment for Federally qualified health centers 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.

‘‘(II) Collection of data and evaluation.—The Secretary shall require Federally qualified health centers to submit to the Secretary such information as the Secretary may require in order to develop and implement the prospective payment system under this paragraph. In so doing, the Secretary shall include the reporting of services using HCPCS codes.

‘‘(3) Implementation.—The Secretary shall:

‘‘(I) implement such prospective payment system so that the estimated amount of expenditures under this title for Federally qualified health services in the first year that the prospective payment system is implemented is equal to 105 percent of the estimated amount of expenditures under this title that would have occurred for such services in such year if the system had not been implemented.

‘‘(II) make such additional expenditures estimated under this subparagraph to such increase are in a primary care or general surgery residency (as determined by the Secretary).

The Secretary may determine whether a hospital has met the requirements under this subsection during such 3-year period in such manner and at such time as the Secretary determines appropriate, including at the end of such 5-year period.

(c) Redistribution of positions if hospital no longer meets certain requirements.—In the case where the Secretary determines that a hospital described in clause (i) or (ii) of such clause, the Secretary shall—

(i) reduce the otherwise applicable resident limit of the hospital specified by such Limit was increased under this paragraph; and

(ii) provide for the distribution of positions attributable to such reduction in accordance with the requirements of this paragraph.

(d) Considerations in redistribution.—In determining whether the increase in the otherwise applicable resident limit is provided under this paragraph, the Secretary shall take into account—

(i) whether the hospital filling the positions made available under this paragraph within the first 3 cost reporting periods beginning on or after July 1, 2011, as determined by the Secretary; and

(ii) whether the hospital has an accredited rural training track (as described in paragraph (4)(H)(iv)).

(e) Priority for certain areas.—In determining for which hospitals the increase in the otherwise applicable resident limit is provided under this paragraph, the Secretary shall distribute the increase to hospitals based on the following factors:

(i) Whether the hospital is located in a State with a resident-to-population ratio in the highest quartile (as determined by the Secretary).

(ii) Whether the hospital is located in a State, a territory of the United States, or a Commonwealth that is among the top 10 States, territories, or Districts in terms of the ratio of—
"(1) the total population of the State, territory, or District living in an area designated (under section 332a(a)(1)(A)) as a health professional shortage area (as of the date of the enactment of this paragraph); to
"(II) the total population of the State, territory, or District (as determined by the Secretary based on the most recent available population data published by the Bureau of the Census).
"(iii) whether the hospital is located in a rural area (as defined in subsection (d)(2)(B)(ii)).

"(E) RESERVATION OF POSITIONS FOR CERTAIN HOSPITALS.—
"(i) EXCEPTION.—Subject to clause (ii), the Secretary shall reserve the positions available for distribution under this paragraph as follows: 
"(I) 70 percent of such positions for distribution to hospitals described in clause (i) of subparagraph (D).

"(ii) 30 percent of such positions for distribution to hospitals described in clause (ii) and (iii) of such subparagraph.

"(F) EXCEPTION IF POSITIONS NOT REDISTRIBUTED BY JULY 1, 2011.—In the case where the Secretary does not distribute positions as described in subparagraph (D) by July 1, 2011, the Secretary shall distribute positions such as otherwise allocate positions as described in subparagraph (C) and the priority described in subparagraph (D).

"(G) APPLICATION OF PER RESIDENT AMOUNTS FOR PRIMARY CARE AND NONPRINCIPAL CARE.—With respect to additional residency positions in a hospital attributable to the increase in such positions as approved under this paragraph, the per resident amount under this subparagraph is deemed to be equal to the hospital's per resident amounts for primary care and nonprincipal care computed under paragraph (2)(D) for that hospital.

"(H) DEFINITIONS.—In this paragraph:
"(i) REFERENCE RESIDENT LEVEL.—The term 'reference resident level' means, with respect to a hospital, the highest resident level for any of the 3 most recent cost reporting periods (ending before the date of the enactment of this subsection) for which the hospital incurred costs described in such subparagraph (in the same manner as they are described in the second sentence, as inserted by the Secretary) in the 3 years preceding such date.

"(ii) RESIDENT LEVEL.—The term 'resident level' has the meaning given such term in paragraph (7)(C)(i).

"(iii) OTHERWISE APPLICABLE RESIDENT LIMIT.—The term 'otherwise applicable resident limit' means, with respect to a hospital, the limit otherwise applicable under subparagraph (v) of paragraph (4) on the resident level for the hospital determined without regard to this paragraph but taking into account paragraph (7)(A).

"(b) IME.—(1) IN GENERAL.—Section 1886(d)(5)(B)(v) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)(v)), in the second sentence, is amended—

"(A) by striking 'section (h)(7)' and inserting 'sections (h)(7) and (h)(8)'; and

"(B) by striking 'it applies' and inserting 'they apply'.

"(2) CONFORMING AMENDMENT.—Section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) is amended by adding at the end the following clause:

"(x) For discharges occurring on or after July 1, 2011, insofar as an additional payment amount under this subparagraph is attributable to positions described in subparagraph (D) of section 1886(h) of such Act (42 U.S.C. 1395ww(h)), the indirect teaching adjustment factor shall be computed in the same manner as provided under clause (ii) with respect to such resident positions.';

"(3) PROVIDING AMENDMENT.—Section 422(b)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173) is amended by striking 'subject to subparagraphs (L) and (M)' and inserting 'paragraphs (L) and (M) of subsection (b) of section 1866 of the Social Security Act'.

"SEC. 5504. COUNTING RESIDENT TIME IN NONPROVIDER SETTINGS.

"(a) GME.—Section 1886(h)(4)(E) of the Social Security Act (42 U.S.C. 1395ww(h)(4)(E)) is amended—

"(1) by striking 'shall be counted and that' and inserting 'shall be counted and that';

"(2) by inserting after clause (i), by striking 'during the time that the resident was engaged in furnishing patient care (as defined in paragraph (5)(K)) in a non-patient care (as defined in paragraph (5)(A)) and that is primarily engaged in furnishing patient care (as defined in paragraph (5)(K)) in non-patient care, such as didactic conferences and seminars, but not including research not associated with the treatment or diagnosis of a particular patient, as such time and activities are defined by the Secretary, shall be counted toward the determination of full-time equivalency.'; and

"(3) by inserting after clause (i), as so inserted, the following new clause:

"(ii) Effective for cost reporting periods beginning on or after July 1, 2010, all the time so spent by a resident shall be counted toward the determination of full-time equivalency, without regard to the setting in which such activities are performed, if a hospital incurs all the costs of the stipends and fringe benefits of the resident during the time the resident spends in that setting, including the hospital incurring, directly or through a third party, such hospitals shall count a proportional share of the time, as determined by written agreement between the hospitals, that a resident spends training in that setting.'; and

"(4) by adding at the end the following flush sentence:

"Any hospital claiming under this subparagraph for time spent in a nonprovider setting shall maintain and make available to the Secretary records regarding the amount of such time and such amount in comparison with amounts of such time in such base year as the Secretary shall specify.

"(b) IME.—Section 1886(d)(5)(B)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) is amended—

"(1) by striking 'effective for discharges occurring on or after October 1, 1997' and inserting 'effective for discharges occurring on or after October 1, 1997, and before July 1, 2010'; and

"(2) by inserting after clause (i), as inserted by paragraph (1), the following new subparagraph:

"(II) In determining the hospital's number of full-time equivalent residents for purposes of this subparagraph, all the time spent by an intern or resident in an approved medical residency training program in a nonprovider setting that is primarily engaged in furnishing patient care as defined in paragraph (5)(K) in non-patient care activities, such as didactic conferences and seminars, but not including research not associated with the treatment or diagnosis of a particular patient, as such time and activities are defined by the Secretary, shall be counted toward the determination of full-time equivalency.'; and

"(3) by inserting the following new subparagraph:

"(III) In determining the hospital's number of full-time equivalent residents for purposes of this subparagraph, all the time spent by an intern or resident in an approved medical residency training program in non-patient care activities, such as didactic conferences and seminars, but not including research not associated with the treatment or diagnosis of a particular patient, as such time and activities are defined by the Secretary, shall be counted toward the determination of full-time equivalency.';

"SEC. 5505. RULES FOR COUNTING RESIDENT TIME IN NONPROVIDER SETTINGS.

"(a) GME.—Section 1886(h)(3) of the Social Security Act (42 U.S.C. 1395ww(h)(3)) is amended—

"(1) in paragraph (4)—

"(A) in subparagraph (E), by striking "subject to subparagraphs (J) and (K), such rules"; and

"(B) by adding at the end the following new subparagraphs:

"(J) TREATMENT OF CERTAIN NONPROVIDER AND DIDACTIC ACTIVITIES.—If the Secretary shall provide that all time spent by an intern or resident in an approved medical residency training program in a nonprovider setting that is primarily engaged in furnishing patient care (as defined in paragraph (5)(K)) in non-patient care activities, such as didactic conferences and seminars, but not including research not associated with the treatment or diagnosis of a particular patient, as such time and activities are defined by the Secretary, shall be counted toward the determination of full-time equivalency.

"(K) TREATMENT OF CERTAIN OTHER ACTIVITIES.—In determining the hospital's number of full-time equivalent residents for purposes of this subparagraph, all the time spent by an intern or resident in an approved medical residency training program on vacation, sick leave, or other approved leave, as such time is determined by the Secretary, that does not prolong the total time the resident is participating in the approved program beyond the normal duration of the program shall be counted toward the determination of full-time equivalency.'

"(b) IME DETERMINATIONS.—Section 1886(d)(5)(B) of such Act (42 U.S.C. 1395ww(d)(5)(B)) is amended by adding at the end the following new clause:

"(x)(I) The provisions of subparagraph (k) of section 1886(h) are applicable under this subparagraph in the same manner as they apply under such subsection.

"(II) In determining the hospital's number of full-time equivalent residents for purposes of this subparagraph, all the time spent by an intern or resident in an approved medical residency training program in non-patient care activities, such as didactic conferences and seminars, as such time and activities are defined by the Secretary, that occurs in the hospital shall be counted toward the determination of full-time equivalency if the hospital—

"(aa) is recognized as a subsection (d) hospital;

"(bb) is recognized as a subsection (d) hospital Puerto Rico hospital;

"(cc) is reimbursed under a reimbursement system authorized under section 1844(b)(3); or

"(dd) is a provider-based hospital outpatient department.

"(III) In determining the hospital's number of full-time equivalent residents for purposes of this subparagraph, all the time spent by an intern or resident in an approved medical residency training program in non-patient care activities, such as didactic conferences and seminars, as such time and activities are defined by the Secretary, that occurs in the hospital shall be counted toward the determination of full-time equivalency if the hospital—

"(aa) is recognized as a subsection (d) hospital;

"(bb) is recognized as a subsection (d) hospital Puerto Rico hospital;

"(cc) is reimbursed under a reimbursement system authorized under section 1844(b)(3); or

"(dd) is a provider-based hospital outpatient department.
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(1) In general.—Except as otherwise provided, the Secretary of Health and Human Services shall implement the amendments made by this section in a manner so as to apply to all resident periods beginning on or after January 1, 1983.

(2) GME.—Section 1886(h)(4)(J) of the Social Security Act, as added by subsection (a)(4), is amended by inserting at the end the following clauses:

(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary shall, or shall provide for the establishment of a mechanism by which the Secretary shall, in order to ensure that there is no duplication of FTE slots, distribute any qualified increase to hospitals in the following priority order (with preference given within each category to hospitals that are members of the same affiliated group (as defined by the Secretary under clause (i) as the closed hospital):

(a) First, to hospitals located in the same area as, or a core-based statistical area contiguous to, the hospital that closed.

(b) Second, to hospitals located in the same state as, or a core-based statistical area contiguous to, the hospital that closed.

(c) Third, to hospitals located in the same region of the country as the hospital that closed.

(d) Fourth, only if the Secretary is not able to distribute the increase to hospitals described in item (cc), to qualifying hospitals in accordance with the provisions of paragraph (b).

(2) Requirement for hospitals in certain areas.—Subject to the succeeding provisions of this subsection, in determining for which hospitals the increase in the otherwise applicable resident limit is provided under such paragraph, the Secretary shall determine whether the increase to hospitals in the following priority order (with preference given within each category to hospitals that are members of the same affiliated group (as defined by the Secretary under clause (i)) as the closed hospital):

(aa) First, to hospitals located in the same area as, or a core-based statistical area contiguous to, the hospital that closed.

(bb) Second, to hospitals located in the same state as, or a core-based statistical area contiguous to, the hospital that closed.

(cc) Third, to hospitals located in the same region of the country as the hospital that closed.

(dd) Fourth, only if the Secretary is not able to distribute the increase to hospitals described in item (cc), to qualifying hospitals in accordance with the provisions of paragraph (b).

(3) Limitation.—The aggregate number of increases in the otherwise applicable resident limits for hospitals under this subsection shall not exceed the number of resident positions in the approved medical residency programs that closed on or after the date described in clause (i).

(4) Administration.—Chapter 35 of title 20, United States Code, shall not apply to the implementation of this subsection.

I. DEMONSTRATION PROJECTS TO PROVIDE LOW-INCOME INDIVIDUALS WITH OPPORTUNITIES TO OBTAIN HEALTH PROFESSIONAL WORKFORCE NEEDS.

(a) Authority to conduct demonstration projects.—Title XX of the Social Security Act (42 U.S.C. 1397 et seq.) is amended by adding at the end the following:

"SEC. 2008. DEMONSTRATION PROJECTS TO PROVIDE LOW-INCOME INDIVIDUALS WITH OPPORTUNITIES TO OBTAIN HEALTH PROFESSIONAL WORKFORCE NEEDS.

"(a) Demonstration Projects To Provide Low-Income Individuals With Opportunities To Obtain Health Professional Workforce Needs.—The Secretary, in consultation with the Secretary of Labor, shall award grants to eligible entities to conduct demonstration projects that are designed to provide eligible individuals with the opportunity to obtain education, training, and care advancement to address health professions workforce needs.

"(b) Eligible Indiviudual.—The term 'eligible individual' means a State, an Indian tribe or tribal organization, an institution of higher education, a public or private nonprofit organization, or a for-profit entity.

"(c) Eligible entity.—An eligible entity is an entity that has a history of providing services to low-income individuals and other community-based organizations.

"(d) Determination.—In this subsection, the term 'demonstration project' means a project that is designed to provide eligible individuals with the opportunity to obtain education, training, and care advancement to address health professions workforce needs.

"(e) Authority to award grants.—The Secretary, in consultation with the Secretary of Labor, shall award grants to eligible entities to conduct demonstration projects that are designed to provide eligible individuals with the opportunity to obtain education, training, and care advancement to address health professions workforce needs.

(4) Definitions.—In this subsection:

(1) 'Eligible Individual' means an individual who has poor access to health care and is eligible for a grant under this subsection.

(2) 'Eligible entity' means an entity that is likely to make a significant contribution to workforce development and that can demonstrate that it is capable of providing the services described in this section.

III. ADVANCEMENT TO ADDRESS HEALTH PROFESSIONS WORKFORCE NEEDS.

A. DRESS HEALTH PROFESSIONS WORKFORCE NEEDS.

(1) AUTHORITY TO CONDUCT DEMONSTRATION PROJECTS.—Title XX of the Social Security Act (42 U.S.C. 1397 et seq.) is amended by adding at the end the following:

"SEC. 2008. DEMONSTRATION PROJECTS TO PROVIDE LOW-INCOME INDIVIDUALS WITH OPPORTUNITIES TO OBTAIN HEALTH PROFESSIONAL WORKFORCE NEEDS.

"(a) Demonstration Projects To Provide Low-Income Individuals With Opportunities To Obtain Health Professional Workforce Needs.—The Secretary, in consultation with the Secretary of Labor, shall award grants to eligible entities to conduct demonstration projects that are designed to provide eligible individuals with the opportunity to obtain education, training, and care advancement to address health professions workforce needs.

"(b) Eligible Indiviudual.—The term 'eligible individual' means a State, an Indian tribe or tribal organization, an institution of higher education, a public or private nonprofit organization, or a for-profit entity.

"(c) Eligible entity.—An eligible entity is an entity that has a history of providing services to low-income individuals and other community-based organizations.

"(d) Determination.—In this subsection, the term 'demonstration project' means a project that is designed to provide eligible individuals with the opportunity to obtain education, training, and care advancement to address health professions workforce needs.

"(e) Authority to award grants.—The Secretary, in consultation with the Secretary of Labor, shall award grants to eligible entities to conduct demonstration projects that are designed to provide eligible individuals with the opportunity to obtain education, training, and care advancement to address health professions workforce needs.

"(f) Application.—The amendments made by this section shall not be applied in a manner that requires reopening of any settled hospital cost reports as to which there is not a jurisdictionally final adverse determination 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. Section 1395ww(h)).

"(g) USE OF FEES.—The Secretary shall make grants under this section for the purpose of conducting demonstration projects to eligible persons and entities, and the Secretary shall implement requirements to assure that the funds under this section are used to the extent practicable to prepare candidates for health professions workforce needs.

"(h) Increasing professional education.—The Secretary shall increase the otherwise applicable resident limit for hospitals under this clause.

IV. REPORTS AND EVALUATION.

(1) Reports and evaluation.—(A) Eligible entities.—An eligible entity awarded a grant to conduct a demonstration project under this subsection shall submit interim reports to the Secretary on the activities carried out under the project and a final report on such activities upon the conclusion of the entities’ participation in the project. Such reports shall include assessments of the effectiveness of such activities with respect to improving outcomes for the eligible individuals participating in the project and with respect to addressing health professions workforce needs in the areas in which the project is conducted.

(B) Evaluation.—The Secretary shall, by contract, grant, or interagency agreement, evaluate the demonstration projects conducted under this subsection. Such evaluation shall include identification of successful activities for creating opportunities for developing and sustaining, particularly with respect to low-income individuals and other entry-level workers, a health professions workforce that has accessible entry points, that meets high standards for education, training, certification, and professional development and that provides increased wages and affordable benefits, including health care coverage, that are responsive to the workforce’s needs.

(2) Report to Congress.—The Secretary shall submit interim reports and, based on the evaluation conducted under subparagraph (B), a final report to Congress on the demonstration projects conducted under this subsection.

V. FAMILY-TO-FAMILY HEALTH INFORMATION CENTERS.

(1) Authority to award grants.—The Secretary of Labor, shall award grants to eligible entities to conduct demonstration projects that are designed to provide eligible individuals with the opportunity to obtain education, training, and care advancement to address health professions workforce needs.

(2) Requirements.—(A) Eligible Individual.—The term 'eligible individual' means an individual who has poor access to health care and is eligible for a grant under this subsection.

(B) Eligible entity.—An eligible entity is an entity that has a history of providing services to low-income individuals and other community-based organizations.

(C) Eligible Individual.—The term 'eligible individual' means an individual who has poor access to health care and is eligible for a grant under this subsection.

(D) Eligible entity.—An eligible entity is an entity that has a history of providing services to low-income individuals and other community-based organizations.
assistance for needy families program funded under part A of title IV.

"(G) TRIBAL COLLEGE OR UNIVERSITY.—The term 'Tribal College or University' has the meaning given such term in section 316(b) of the Higher Education Act of 1965 (20 U.S.C. 1069c(b))."

"(b) DEMONSTRATION PROJECT TO DEVELOP TRAINING AND CERTIFICATION PROGRAMS FOR PERSONAL OR HOME CARE AIDES.—

"(1) AUTHORITY TO AWARD GRANTS.—Not later than 18 months after the date of enactment of this section, the Secretary shall award grants to eligible entities that are States to conduct demonstration projects for purposes of developing core training competencies and certification programs for personal or home care aides. The Secretary shall—

"(A) evaluate the efficacy of the core training competencies described in paragraph (3)(A) for newly hired personal or home care aides and the methods used by States to implement such core training competencies in accordance with the issues specified in paragraph (3)(B); and

"(B) ensure that the number of hours of training provided by States under the demonstration project with respect to such core training competencies are not less than the number of hours of training required under any applicable State or Federal law or regulation.

"(2) DURATION.—A demonstration project shall be conducted under this subsection for not less than 3 years.

"(3) CORE TRAINING COMPETENCIES FOR PERSONAL OR HOME CARE AIDES.—

"(A) IN GENERAL.—The core training competencies for personal or home care aides described in this subparagraph include the following:

"(i) The role of the personal or home care aide (including differences between a personal or home care aide employed by an agency and a personal or home care aide employed directly by the health care consumer or an independent provider).

"(ii) Consumer rights, ethics, and confidentiality (including the role of proxy decision-makers in the case where a health care consumer has impaired decision-making capacity).

"(iii) Communication, cultural and linguistic competence and sensitivity, problem solving, behavior management, and relationship skills.

"(iv) Personal care skills.

"(v) Health care support.

"(vi) Nutritional support.

"(vii) Infection control.

"(viii) Safety and emergency training.

"(ix) Training specific to an individual consumer's needs (including older individuals, persons with individual disabilities, individuals with developmental disabilities, individuals with dementia, and individuals with mental and behavioral health needs).

"(x) In-service training.

"(B) IMPLEMENTATION.—The implementation issues specified in this subparagraph include the following:

"(i) The length of the training.

"(ii) The appropriate trainer to student ratio.

"(iii) The amount of instruction time spent in the classroom as compared to on-site in the home or a facility.

"(iv) Trainer qualifications.

"(v) Content for a 'hands-on' and written certification exam.

"(vi) Continuing education requirements.

"(B) APPLICATION AND ELIGIBILITY.—A State seeking to participate in the project shall—

"(i) submit an application to the Secretary containing such information and at such time as the Secretary may specify;

"(ii) meet the selection criteria established under subparagraph (C); and

"(iii) meet such additional criteria as the Secretary may specify.

"(C) SELECTION CRITERIA.—In selecting States to participate in the program, the Secretary shall establish criteria to ensure (if applicable with respect to the activities involved)—

"(i) geographic and demographic diversity;

"(ii) that participating States offer medical assistance for personal care services under the State Medicaid plan;

"(iii) that the existing training standards for personal or home care aides in each participating State—

"(I) are different from such standards in the other participating States; and

"(II) are different from the core training competencies described in paragraph (3)(A);

"(IV) that participating States do not reduce the number of hours of training required under applicable State law or regulation after being selected to participate in the project; and

"(V) that participating States recruit a minimum number of eligible health and long-term care providers to participate in the project.

"(D) TECHNICAL ASSISTANCE.—The Secretary shall provide technical assistance to States in developing written materials and protocols for such core training competencies.

"(E) EVALUATION AND REPORT.—

"(A) EVALUATION.—The Secretary shall develop an experimental or control group testing protocol in consultation with an independent entity and a core training competency, including criteria developed to implement such core training competencies, for personal or home care aides within each participating State on job satisfaction, mastery of job skills, beneficiary and family caregiver satisfaction with services, and additional measures determined by the Secretary in consultation with the expert panel:

"(i) the impact of core training competencies described in paragraph (3)(A), including curricula developed to implement such core training competencies, for personal or home care aides within each participating State on job satisfaction, mastery of job skills, beneficiary and family caregiver satisfaction with services, and additional measures determined by the Secretary in consultation with the expert panel;

"(ii) the impact of providing such core training competencies on the existing training infrastructure and resources of States; and

"(iii) whether a minimum number of hours of initial training should be required for personal or home care aides and, if so, what the minimum number of hours should be required.

"(B) REPORTS.—

"(1) REPORT ON INITIAL IMPLEMENTATION.—Not later than 2 years after the date of enactment of this section, the Secretary shall submit to Congress a report on the initial implementation of activities conducted under the demonstration project, including any available results of the evaluation conducted under subparagraph (A) with respect to such activities, together with recommendations for legislation or administrative action as the Secretary determines appropriate.

"(2) FINAL REPORT.—Not later than 1 year after the completion of the demonstration project, the Secretary shall submit to Congress a report containing the results of the evaluation conducted under subparagraph (A), together with such recommendations for legislation or administrative action as the Secretary determines appropriate.

"(F) DEFINITIONS.—In this subsection:

"(A) ELIGIBLE HEALTH AND LONG-TERM CARE PROVIDER.—The term 'eligible health and long-term care provider' means a personal or home care agency (including personal or home care public authorities), a nursing home, a home health agency (as defined in section 1861(o)), or any other health care provider the Secretary determines appropriate which—

"(i) is licensed or authorized to provide services in a participating State; and

"(ii) receives payment for services under title XIX.

"(B) PERSONAL CARE SERVICES.—The term 'personal care services' has the meaning given such term for purposes of title XIX.

"(C) PERSONAL OR HOME CARE AIDE.—The term 'personal or home care aide' means an individual who helps individuals who are elderly, disabled, ill, or mentally disabled (including an individual with Alzheimer's disease or other dementia) to live in their own home or a residential care facility (such as a nursing home, assisted living facility, or any other facility the Secretary determines appropriate) by providing routine personal care services and other appropriate services to the individual.

"(D) STATE.—The term 'State' has the meaning given that term for purposes of title XIX.

"(E) FUNDING.—

"(i) IN GENERAL.—Subject to paragraph (2), out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary to carry out subsections (a) and (b), $5,000,000 for each of fiscal years 2010 through 2014.

"(ii) NONAPPLIcATION.—In general.—Except as provided in paragraph (2), the preceding sections of this title shall not apply to grants awarded under this section.

"(F) LIMITATIONS ON USE OF GRANTS.—Section 3001(a) (other than paragraph (6)) shall apply to a grant awarded under this section to the same extent and in the same manner as such section applies to payments to States under this title.".

"(G) EXTENSION OF FAMILY-TO-FAMILY HEALTH INFORMATION CENTERS.—Section 561(c)(1)(A)(ii) of the Social Security Act (42 U.S.C. 1396p(c)(1)(A)(ii)) is amended by striking "fiscal year 2009" and inserting "each of fiscal years 2009 through 2012".
SEC. 5508. INCREASING TEACHING CAPACITY.

(a) Teaching Health Centers Training and Enhancement.—Part C of title VII of the Public Health Service Act (42 U.S.C. 293c et seq.), section 338C(a), is further amended by inserting after section 338D the following:

"SEC. 338A. TEACHING HEALTH CENTERS DEVELOPMENT GRANTS."

"(a) Program Authorized.—The Secretary may award grants under this section to teaching health centers for the purpose of establishing new accredited or expanded primary care residency programs.

(b) Duration.—Grants awarded under this section shall be for a term of not more than 3 years and the maximum award may not be more than $500,000.

(c) Amounts Provided.—Amounts provided under a grant under this section shall be used to cover the costs of—

(1) establishing or expanding a primary care residency training program described in subsection (a), including costs associated with—

(A) curriculum development;

(B) recruitment, training and retention of residents and faculty;

(C) accreditation by the Accreditation Council for Graduate Medical Education (ACGME), the American Dental Association (ADA), or the American Osteopathic Association (AOA); and

(D) faculty salaries during the development phase;

(2) technical assistance provided by an eligible entity.

(d) Application.—A teaching health center seeking a grant under this section shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(e) Preference for Certain Applications.—In awarding grants under this section, the Secretary shall give preference to any application that documents an existing affiliation agreement with an area health education program as defined in sections 751 and 799B.

(f) Definitions.—In this section:

"(1) Eligible entity.—The term 'eligible entity' means an organization capable of providing technical assistance including an area health education program as defined in sections 751 and 799B.

"(2) Primary Care Residency Program.—The term 'primary care residency program' means an approved graduate medical residency program (as defined in section 340H) in family medicine, internal medicine, pediatrics, internal medicine-pediatrics, obstetrics and gynecology, psychiatry, general dentistry, pediatric dentistry, and geriatrics.

"(3) Teaching Health Center.—

"(A) In General.—The term 'teaching health center' means an entity that—

(i) is a community based, ambulatory patient care center; and

(ii) operates a primary care residency program.

"(B) Inclusion of Certain Entities.—Such term includes the following:

(i) a government operated health center (as defined in section 1905(s)(2)(B) of the Social Security Act).

(ii) A community mental health center (as defined in section 1961(f)(3)(B) of the Social Security Act).

(iii) A rural health clinic, as defined in section 1961(aa) of the Social Security Act.

(iv) Any entity operated by the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization (as defined in section 4 of the Indian Health Care Improvement Act).

(v) An entity receiving funds under title X of the Public Health Service Act.

"(g) Authorization of Appropriations.—There is authorized to be appropriated, $25,000,000 for fiscal year 2010, $50,000,000 for fiscal year 2011, $50,000,000 for fiscal year 2012, $80,000,000 for fiscal year 2013, $100,000,000 for fiscal year 2014, and such sums as may be necessary for fiscal year 2015 and each fiscal year thereafter to carry out this section. Not to exceed $5,000,000 annually may be used for technical assistance program grants.

(b) National Health Service Corps Training Centers.

SEC. 338C. PROGRAM OF PAYMENTS TO TEACHING HEALTH CENTERS THAT OPERATE A GRADUATE MEDICAL EDUCATION PROGRAM.

(a) Payments.—Subject to subsection (h), the Secretary shall make payments under this section to direct graduate medical education programs for direct graduate medical residency training programs as determined under section 338D(c)(2)(D) of the Social Security Act (without regard to the limitation under subparagraph (F) of such section) during the fiscal year.

(b) Amount of Payments.—

"(1) In General.—The amount determined under this subsection for payments to qualified teaching health centers for direct graduate medical education programs is equal to an amount determined appropriate by the Secretary.

"(2) Capped Amount.—The amount determined under paragraph (1) do not exceed the amount appropriated as determined under section 338D(c)(2)(D) of the Social Security Act.

"(3) Interim Payment.—Before the Secretary makes a payment under this subsection pursuant to a determination of indirect expenses under section 338D(c)(2)(D) of the Social Security Act, the Secretary shall provide such payment to qualified teaching health centers for a fiscal year is an amount determined as follows:

(A) Determination of Qualified Teaching Health Centers.—The Secretary shall compute for each individual qualified teaching health center a per resident amount.

(B) by dividing the national average per resident amount computed under section 338D(c)(2)(D) into a wage-related portion and a non-wage related portion by applying the proportion determined under subparagraph (B);

(ii) by multiplying the wage-related portion by the factor applied under section 338D(c)(2)(D) of the Social Security Act (but without application of section 4110 of the Balanced Budget Act of 1997 (42 U.S.C. 1320v note)) during the preceding fiscal year for the teaching health center's area; and

(iii) by adding the non-wage-related portion to the amount computed under clause (ii).

(C) Payment for Direct Graduate Medical Education.—Payments under this subsection for qualified teaching health centers for indirect expenses associated with the additional costs of teaching residents for a fiscal year is equal to an amount determined appropriate by the Secretary.

(D) Factors.—In determining the amount under paragraph (1), the Secretary shall consider—

(A) evaluate indirect training costs relative to supporting a primary care residency program in qualified teaching centers.

(B) based on this evaluation, assure that the aggregate of the payments for indirect expenses under this section and the payments for direct graduate medical education as determined under subsection (c) in a fiscal year do not exceed the amount appropriated for such expenses as determined in subsection (g).

(E) Limitation.—The Secretary shall limit the funding of full-time equivalent residents in order to ensure the direct and indirect payments are determined as described above taking into account the following:

(i) the funding of full-time equivalent residents in order to ensure the direct and indirect payments are determined as described above taking into account the following;

(ii) the funding of full-time equivalent residents in order to ensure the direct and indirect payments are determined as described above taking into account the following;

(iii) the funding of full-time equivalent residents in order to ensure the direct and indirect payments are determined as described above taking into account the following;

(iv) the funding of full-time equivalent residents in order to ensure the direct and indirect payments are determined as described above taking into account the following;

(v) the funding of full-time equivalent residents in order to ensure the direct and indirect payments are determined as described above taking into account the following;

(vi) the funding of full-time equivalent residents in order to ensure the direct and indirect payments are determined as described above taking into account the following;

(vii) the funding of full-time equivalent residents in order to ensure the direct and indirect payments are determined as described above taking into account the following;

(viii) the funding of full-time equivalent residents in order to ensure the direct and indirect payments are determined as described above taking into account the following;

(ix) the funding of full-time equivalent residents in order to ensure the direct and indirect payments are determined as described above taking into account the following;

(x) the funding of full-time equivalent residents in order to ensure the direct and indirect payments are determined as described above taking into account the following;

(xi) the funding of full-time equivalent residents in order to ensure the direct and indirect payments are determined as described above taking into account the following;

(xii) the funding of full-time equivalent residents in order to ensure the direct and indirect payments are determined as described above taking into account the following;

(xiii) the funding of full-time equivalent residents in order to ensure the direct and indirect payments are determined as described above taking into account the following;

(xiv) the funding of full-time equivalent residents in order to ensure the direct and indirect payments are determined as described above taking into account the following;

(xv) the funding of full-time equivalent residents in order to ensure the direct and indirect payments are determined as described above taking into account the following;

(xvi) the funding of full-time equivalent residents in order to ensure the direct and indirect payments are determined as described above taking into account the following;

(xvii) the funding of full-time equivalent residents in order to ensure the direct and indirect payments are determined as described above taking into account the following;

(xviii) the funding of full-time equivalent residents in order to ensure the direct and indirect payments are determined as described above taking into account the following;

(xix) the funding of full-time equivalent residents in order to ensure the direct and indirect payments are determined as described above taking into account the following;

(xx) the funding of full-time equivalent residents in order to ensure the direct and indirect payments are determined as described above taking into account the following;

(2) Limitation.—The amount determined under paragraph (1) do not exceed the amount appropriated as determined under subsection (c) in a fiscal year do not exceed the amount appropriated as determined under paragraph (1).

(3) Interim Payment.—Before the Secretary makes a payment under this subsection pursuant to a determination of indirect expenses under section 338D(c)(2)(D) of the Social Security Act, the Secretary shall provide such payment to qualified teaching health centers for a fiscal year, in addition to any payment made under subsection (c), for expected indirect expenses associated with the additional costs of teaching residents for a fiscal year, based on an estimate by the Secretary of the amount.

(F) Clarification Regarding Relationship to Other Payments for Graduate Medical Education.—Payments under this section—

"(1) shall be in addition to any payments—

(A) for the indirect costs of medical education as determined under section 1866(d) of the Social Security Act;

(B) for direct graduate medical education costs under section 1866(b) of such Act; and—
“(C) for direct costs of medical education under section 1886(k) of such Act; 

“(2) shall not be taken into account in ap-
plying the limitation on the number of total full-time residents under paragraphs (F) and (G) of section 1886(h)(4) of such Act and clauses (v), (vi)(I), and (vi)(II) of section 1886(d)(5)(B) of such Act for the portion of time that a resident rotates to a hospital; and 

“(3) shall not include the time in which a resident is counted toward full-time equiva-
lence for the purposes of subparagraph (2) or under section 1886(d)(5)(B)(iv) of the Social Security Act, section 1886(h)(4)(E) of such Act, or section 190E of this Act. 

“(f) The Secretary shall determine any changes to the number of residents reported by a hospital in the appli-
cation of the hospital for the current fiscal year to determine the final amount payable to the hospital for the current fiscal year for both direct expense and indirect expense amounts. Based on such determination, the Secretary shall recoup any overpayments made to any balance due to the extent possible. The final amount so determined shall be considered a final determination for the purposes of section 1878 of the Social Security Act and shall be subject to administrative and judicial review for the purposes of section 1878 of such Act, or section 190E of this Act. 

“(g) (1) ESTABLISHMENT.—(A) The types of primary care resident ap-
proved training programs that the qualified teaching health center provided for resi-
dents 

“(B) The number of approved training posi-
tions for residents described in paragraph (4). 

“(C) The number of residents described in paragraph (4) who completed their residency training at the end of such residency aca-
demic year and care for vulnerable popu-
lations.

“(D) Other information as deemed appro-
priate by the Secretary. 

“(h) AUDIT AUTHORITY; LIMITATION ON PAY-
MENT.—(A) Audit Authority.—The Secretary may audit a qualified teaching health center to ensure the accuracy and completeness of the information submitted in a report under paragraph (1). 

“(B) LIMITATION ON PAYMENT.—A teaching health center may only receive payment in a cost reporting period for a number of such fiscal years 2011 through 2015. 

“(1) ESTABLISHMENT.—(A) The term ‘primary care residency program’ has the meaning given that term in section 179A. 

“(B) QUALIFIED TEACHING HEALTH CENTER.—The term ‘qualified teaching health center’ has the meaning given that term in section 179A. 

“(C) RESIDENTS.—The term ‘residents described in this paragraph are those who are in part-
time or full-time equivalent resident train-
ing positions at a qualified teaching health center as determined by the Secretary. For purposes of this subparagraph, the ‘base level of primary care resident positions’ for a teaching health center in the level of such residents as of a base period. 

“(D) DESTRUCTION IN PAYMENT FOR FAILURE TO REPORT.—

“(A) IN GENERAL.—The amount payable under this section to a qualified teaching health center for a fiscal year shall be reduced by at least 25 percent if the Secretary determines that— 

“(i) the qualified teaching health center has failed to report under this section, as an ad-
dendum to the qualified teaching health cen-
ter’s application under this section for such fiscal year, the report required under para-
graph (1) for the previous fiscal year; or 

“(ii) such report fails to provide complete and accurate information required under any subparagraph of this subsection. 

“(B) NOTICE AND OPPORTUNITY TO PROVIDE 

ACCURATE AND MISSING INFORMATION.—Before imposing a reduction under subparagraph (A) the Secretary shall provide no-
less than 30 days to the teaching health center to provide the required information within the period of 30 days beginning on the date of failure and the Secretary’s intention to impose such reduction and shall provide the teaching health center with the opportunity to provide the required information within the period of 30 days beginning on the date of such notice. If the teaching health center provides such information within such period, no reduction shall be made under subparagraph (A) on the basis of the previous failure to provide such information. 

“(4) REGULATIONS.—The Secretary shall promulgate regulations to carry out this sec-
tion. 

“(j) DEFINITIONS.—In this section: 

“(1) APPROVED GRADUATE MEDICAL RESIDENCY PROGRAM.—The term ‘approved graduate medical residency training program’ means a residency or other post-
graduate medical training program— 

“(A) in which the completion of which is count-
et toward certification in a specialty or sub-
speciality and includes formal postgraduate training programs in geriatric medicine ap-
proved by the Accreditation Council for Graduate Medical Education 

“(B) that meets criteria for accreditation (as established by the Accreditation Council for Graduate Medical Education, the Amer-
ican Osteopathic Association, or the Amer-
ican Dental Association). 

“(2) PRIMARY CARE RESIDENCY PROGRAM.—The term ‘primary care residency program’ has the meaning given that term in section 179A. 

“(3) QUALIFIED TEACHING HEALTH CENTER.—The term ‘qualified teaching health center’ has the meaning given that term in section 179A. 

“SECTION 5509. GRADUATE NURSE EDUCATION DEM-
ONSTRATION. 

“(a) IN GENERAL.—

“(1) ESTABLISHMENT.— (A) The Secretary shall es-
establish a demonstration on em-
donstration under title XVIII of the Social Sec-
urity Act (42 U.S.C. 1395 et seq.) under which an eligible hospital may receive pay-
ment for an increase in the number of ad-
dvanced practice registered nurses that are at-
tributable to an increase in the number of ad-
dvanced practice registered nurses with respect to a specific base year as a result of the demo-
stration. 

“(2) COSTS DESCRIBED.—The costs described in subsection (d) of this section to a hospital operated by the applicable school of nurs-
ing that is an eligible partner of the hos-
ital. Such written agreement shall include an analysis of the following: 

“(1) The growth in the number of advanced practice registered nurses with respect to a specific base year as a result of the demo-

“(2) The growth in each of the specialties described in subparagraphs (A) through (D) of this section. 

“(3) The costs to the Medicare program under title XVIII of the Social Security Act as a result of the demonstration. 

“(B) LIMITATION.—With respect to a year, the amount reimbursed under subparagraph (A) may not exceed the amount of costs de-
scribed in subparagraph (A) that are attrib-
utable to an increase in the number of ad-
dvanced practice registered nurses enrolled in a program that provides qualified training during the year for which the hospital is being reimbursed under this section, as compared to the average number of ad-
dvanced practice registered nurses who graduated in each year during the period begin-
ing on January 1, 2006, and ending on De-
cember 31, 2010 (as determined by the Sec-
cretary) from the graduate nursing education program operated by the applicable school of nurs-
ing that is an eligible partner of the hospital for purposes of the demonstration. 

“(c) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act as may be neces-

“(d) FUNDING.—There is hereby appro-
riated to the Secretary, out of any funds in the Treasury not otherwise appropriated, $50,000,000 for each of fiscal years 2012 through 2015 to carry out this section, in-
cluding the design, implementation, mon-
toring, and evaluation of the demonstration. 

“(1) IN GENERAL.—There is hereby appro-
riated to the Secretary of Health and Human Services, for each of the fiscal years 2012 through 2015 $50,000,000 to carry out this section, in-
cluding the design, implementation, mon-
toring, and evaluation of the demon-
stration. 

“(2) LIMITATION.—With respect to a year, the amount reimbursed under subparagraph (A) may not exceed the amount of costs de-
scribed in subparagraph (A) that are attrib-
utable to an increase in the number of ad-
dvanced practice registered nurses enrolled in a program that provides qualified training during the year for which the hospital is being reimbursed under this section, as compared to the average number of ad-
dvanced practice registered nurses who graduated in each year during the period begin-
ing on January 1, 2006, and ending on De-
cember 31, 2010 (as determined by the Sec-
cretary) from the graduate nursing education program operated by the applicable school of nurs-
ing that is an eligible partner of the hospital for purposes of the demonstration. 

“(e) DEFINITIONS.—In this section: 

“(1) ADVANCED PRACTICE REGISTERED NURSE.—The term ‘advanced practice registered nurse’ includes the following: 

“(A) A clinical nurse specialist (as defined in subsection (aa)(5) of section 1861 of the So-

“(B) A nurse practitioner (as defined in subsection (bb)(2) of such section).
(D) A certified nurse-midwife (as defined in subsection (gg)(2) of such section).

(2) APPLICABLE NON-HOSPITAL COMMUNITY-BASED CARE SETTING.—The term ‘‘applicable non-hospital community-based care setting’’ means a non-hospital community-based care setting which has entered into a written agreement (as described in subsection (b)) with a single eligible hospital participating in the demonstration. Such settings include Federally qualified health centers, rural health clinics, and other non-hospital community-based care settings as determined appropriate by the Secretary.

(3) APPLICABLE SCHOOL OF NURSING.—The term ‘‘applicable school of nursing’’ means an accredited school of nursing (as defined in section 801 of the Public Health Service Act) which has entered into a written agreement (as determined in subsection (b)) with an eligible hospital participating in the demonstration. Such settings include hospitals, rural health clinics, and other non-hospital settings as determined appropriate by the Secretary.

(4) DEMONSTRATION.—The term ‘‘demonstration’’ means the graduate nurse education demonstration established under subsection (a).

(5) ELIGIBLE HOSPITAL.—The term ‘‘eligible hospital’’ (as defined in subsection (e) of section 1861 of the Social Security Act, a low-volume hospital (as defined for purposes of section 1886 of such Act), a critical access hospital, a sole community hospital (as defined for purposes of section 1886(d)(5)(G)(iv) of such Act) for the delivery of primary health care services that are available at the clinic or hospital to individuals who would otherwise be eligible for free or reduced cost care if such individual were to receive care at the community health center. Such services may be limited in scope to those primary health care services available in that clinic or hospital.

(6) ASSURANCES.—In order for a clinic or hospital to receive funds under this section through a contract with a community health center under subparagraph (A), such clinic or hospital shall establish policies to ensure—

‘‘(i) nondiscrimination based on the ability of a patient to pay; and

‘‘(ii) the establishment of a sliding fee scale for low-income patients.’’.

SEC. 5602. NEGOTIATED RULEMAKING FOR DESIGNING MEDICALLY UNDERSERVED POPULATIONS AND HEALTH PROFESSIONALS SHORTAGE AREAS.

(a) Establishment.—

‘‘(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ‘Secretary’’) shall establish, through a negotiated rulemaking process under subchapter V of title 5, United States Code, a comprehensive methodology and criteria for designation of—

(i) medically underserved populations in accordance with subsection (b) of the Public Health Service Act (42 U.S.C. 254b(b));

(ii) health professions shortage areas under section 332 of the Public Health Service Act (42 U.S.C. 254e).

‘‘(2) FACTORS TO CONSIDER.—In establishing the methodology and criteria under paragraph (1), the Secretary—

‘‘(A) shall consult with relevant stakeholders who will be significantly affected by a rule (such as national, State and regional organizations representing affected entities, State health or governmental organizations, health centers and other affected entities, and other interested parties; and

‘‘(B) shall—

‘‘(i) the timely availability and appropriateness of data used to determine a designation to potential applicants for such designations;

‘‘(ii) each methodology and criteria on various types of and on health centers and other safety net providers;

‘‘(iii) the degree of ease or difficulty that will face potential applicants for such designations;

‘‘(iv) the extent to which the methodology accurately identifies and removes barriers that confront individuals and population groups in seeking health care services.

(b) Publication of Notice.—In carrying out the rulemaking process under this subsection, the Secretary shall publish the notice provided for under section 56(a) of title 5, United States Code, not later than 30 days after the end of the comment period provided for under section 56(c) of such title; and

(2) the nomination of a facilitator under section 56(c) of such title 5 by not later than 10 days after the date of appointment of the committee.

(c) Preliminary Committee Report.—If the committee has not submitted a report containing a proposed rule by not later than 3 months after the date of appointment of the committee.

(d) Final Committee Report.—If the committee has not submitted a report containing a proposed rule by not later than one year before the target publication date.

(e) Interim Final Effect.—The Secretary shall publish a rule under this section in the Federal Register by not later than the target publication date. Such rule shall be effective and final immediately on an interim basis, but is subject to change and revision after public notice and opportunity for a period of not less than 90 days. In connection with such rule, the Secretary shall specify the process for the timely review and approval of applications for such designations pursuant to such rules and consistent with this section.

(f) Publication of Rule After Public Comment.—The Secretary shall provide for consideration of such comments and republication of such rule by not later than 1 year after the target publication date.

SEC. 5603. REAUTHORIZATION OF THE WAKEFIELD EMERGENCY MEDICAL SERVICES FOR CHILDREN PROGRAM.

Section 1910 of the Public Health Service Act (42 U.S.C. 300b-9) is amended by striking ‘‘3-year period (with an optional 4th year)’’ and inserting ‘‘4-year period (with an optional 5th year)’’; and

(1) in subsection (a), by striking ‘‘3-year period (with an optional 4th year)’’ and inserting ‘‘4-year period (with an optional 5th year)’’; and

(2) in subsection (d)—

(A) by striking ‘‘such rules’’ and inserting ‘‘such rules’’; and

(B) by inserting both in the period the following: ‘‘$25,000,000 for fiscal year 2010, $25,250,000 for fiscal year 2011, $27,562,300 for fiscal year 2012, $30,940,625 for fiscal year 2013, and $30,387,656 for fiscal year 2014’’. 

SEC. 5604. CO-LOCATING PRIMARY AND SPECIALTY CARE IN COMMUNITY-BASED HEALTH CENTERS.

Subpart 3 of part B of title V of the Public Health Service Act (42 U.S.C. 290b–31 et
SEC. 5200. AWARDS FOR CO-LOCATING PRIMARY AND SPECIALTY CARE IN COMMUNITY-BASED MENTAL HEALTH SETTINGS.

(a) Definitions.—In this section:

(1) Eligible entity.—The term "eligible entity" means a qualified community mental health program defined under section 1912(b)(1).

(2) Social populations.—The term ‘social populations’ means adults with mental illnesses who have co-occurring primary care conditions and chronic diseases.

(b) Program requirement.—The Secretary, acting through the Administrator shall award grants and cooperative agreements to establish demonstration projects for the provision of co-ordinated and integrated services to special populations through the co-location of primary and specialty care services in community-based mental and behavioral health settings.

(c) Application.—To be eligible to receive a grant or cooperative agreement under this section, an eligible entity shall submit an application to the Administrator at such time, in such manner, and by such form as the Administrator may require, including a description of partnerships, or other arrangements with local primary care providers, including community health centers, to provide services to special populations.

(d) Use of funds.—

(1) In general.—For the benefit of special populations, an eligible entity shall use funds awarded under this section for—

(A) the provision, by qualified primary care professionals, of on site primary care services;

(B) reasonable costs associated with medically necessary referrals to qualified specialty care professionals, other coordinators of care or, if permitted by the terms of the grant or cooperative agreement, by qualified specialty care professionals on a reasonable cost basis on site at the eligible entity;

(C) information technology required to accommodate the clinical needs of primary and specialty care professionals; or

(D) facilities needed to bring primary and specialty care professionals on site at the eligible entity.

(2) Limitation.—Not to exceed 15 percent of grant or cooperative agreement funds may be used for activities described in subparagraphs (C) and (D) of paragraph (1).

(e) Evaluation.—Not later than 90 days after a grant or cooperative agreement awarded under this section expires, an eligible entity shall submit to the Secretary the results of an evaluation to be conducted by the entity concerning the effectiveness of the activities carried out under the grant or agreement.

Authorization of appropriations.—There are authorized to be appropriated to carry out this section, $50,000,000 for fiscal year 2010 and such sums as may be necessary for each of fiscal years 2011 through 2014.

SEC. 5005. KEY NATIONAL INDICATORS.

(a) Definitions.—In this section:

(1) Academy.—The term ‘Academy’ means the National Academy of Sciences.

(2) Commission.—The term ‘Commission’ means the Commission on Key National Indicators established under subsection (b).

(b) Commission on Key National Indicators.—

(1) Establishment.—There is established a "Commission on Key National Indicators".

(2) Membership.—

(A) Number and appointment.—The Commission shall be composed of 8 members, to be appointed equally by the majority and minority leaders of the Senate and the Speaker and minority leader of the House of Representatives.

(B) Prohibitions.—Members of the Commission shall not include Members of Congress or other elected Federal, State, or local government officials.

(C) Qualifications.—In making appointments under paragraph (A), the majority and minority leaders of the Senate and the Speaker and minority leader of the House of Representatives shall appoint individuals who have shown a dedication to improving civic dialogue and decision-making through the wide use of scientific evidence and factual information.

(D) Period of appointment.—Each member of the Commission shall be appointed for a 2-year term, except that each initial appointment shall last only for the remainder of that term.

(E) Date.—Members of the Commission shall be appointed by not later than 30 days after the date of enactment of this Act.

(F) Initial organizing period.—Not later than 60 days after the date of enactment of this Act, the Commission shall develop and implement a key national indicator system.

(g) Co-Chairsperson.—The Commission shall select 2 Co-Chairsperson from among its members.

(c) Duties of the Commission.—

(1) In general.—The Commission shall—

(A) conduct comprehensive oversight of a newly established key national indicators system consistent with the purpose described in this subsection;

(B) make recommendations on how to improve the key national indicators system;

(C) coordinate with Federal Government users and information providers to assure access to relevant and quality data; and

(D) enter into contracts with the Academy.

(2) Report to Congress.—

(A) Annual report to Congress.—Not later than 1 year after the selection of the 2 Co-Chairs' of the Commission, and each Co-Chairs shall submit a report to the Commission a report making recommendations concerning potential issue areas and key indicators to be included in the Key National Indicators System.

(B) Annual report to the academy.—

(I) In general.—Not later than 6 months after the selection of the 2 Co-Chairs, the Commission shall prepare and submit to the Academy a report containing the key national indicators.

(II) Partnership with a private organization.—If the Academy designates an Institute under clause (i)(II), the Commission shall enter into an arrangement with the National Academy of Sciences to establish a web-accessible database.

(i) In general.—Not later than 6 months after the selection of the 2 Co-Chairs, the Commission shall prepare and submit to the Academy a report containing the key national indicators.

(ii) Partnership with a private organization.—If the Academy designates an Institute under clause (i)(II), the Commission shall enter into an arrangement with the National Academy of Sciences to establish a web-accessible database.

(ii) In general.—Not later than 6 months after the selection of the 2 Co-Chairs, the Commission shall prepare and submit to the Academy a report containing the key national indicators.

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(ii) In general.—Not later than 6 months after the selection of the 2 Co-Chairs, the Commission shall prepare and submit to the Academy a report containing the key national indicators.

(iii) Partnership with a private organization.—If the Academy designates an Institute under clause (i)(II), the Commission shall enter into an arrangement with the National Academy of Sciences to establish a web-accessible database.

(iv) Designing, publishing, and maintaining a public website that contains a freely accessible database allowing public access to the key national indicators.

(V) Developing a quality assurance framework to ensure rigorous and independent peer review of the selection of quality data.

(VI) Developing a budget for the construction and management of a sustainable, multi-sector, multi-disciplinary process to develop and maintain the key national indicators.

(VII) Reviewing any inquiries by the Academy.

(VIII) Responding directly to the Commission in response to any Commission recommendations to and from the Commission in response to any Commission recommendations.

(V) Developing a budget for the construction and management of a sustainable, multi-sector, multi-disciplinary process to develop and maintain the key national indicators.

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(VI) Developing a budget for the construction and management of a sustainable, multi-sector, multi-disciplinary process to develop and maintain the key national indicators.

(VII) Reviewing any inquiries by the Academy.

(VIII) Responding directly to the Commission in response to any Commission recommendations to and from the Commission in response to any Commission recommendations.
TITLE VI—TRANSPARENCY AND PROGRAM INTEGRITY

Subtitle A—Physician Ownership and Other Transparency

SEC. 6001. LIMITATION ON MEDICARE EXCEPTED TO THE PROHIBITION ON CERTAIN PHYSICIAN REFERRALS FOR HOSPITALS.

(a) IN GENERAL.—Section 1877 of the Social Security Act (42 U.S.C. 1395nn) is amended—

(1) in subsection (d)(2)—

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

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

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

"(C) in the case where the entity is a hospital, the hospital meets the requirements of paragraph (3)(D);"

(2) in subsection (d)(3)—

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

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

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

"(D) the hospital meets the requirements described in subsection (i)(1) not later than 18 months after the date of the enactment of this subparagraph;" and

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

"(i) REQUIREMENTS FOR HOSPITALS TO QUALIFY FOR RURAL PROVIDER AND HOSPITAL EXCEPTION TO OWNERSHIP OR INVESTMENT PROHIBITION.—

"(1) REQUIREMENTS DESCRIBED.—For purposes of subsection (d)(3)(D), the requirements described in this paragraph for a hospital are as follows:

"(A) PROVIDER AGREEMENT.—The hospital had—

"(i) physician ownership or investment on February 1, 2010; and

"(ii) a provider agreement under section 1866 in effect on such date.

"(B) LIMITATION ON EXPANSION OF FACILITY CAPACITY.—Except as provided in paragraph (3), the number of operating rooms, procedure rooms, and beds for which the hospital is licensed at any time on or after the date of this subsection is no greater than the number of operating rooms, procedure rooms, and beds for which the hospital is licensed as of such date.

"(C) PROVIDER AGREEMENT.—

"(i) The hospital submits to the Secretary an annual report containing a detailed description of—

"(I) the identity of each physician owner or investor and any other owners or investors of the hospital; and

"(II) the nature and extent of all ownership and investment in the hospital.

"(ii) The hospital has procedures in place to require that any referring physician owner or investor discloses to the patient being referred of this fact; and permits the patient to make a meaningful decision regarding the receipt of care, as determined by the Secretary.

"(ii) The hospital has the capacity to—

"(I) provide assessment and initial treatment for patients; and

"(II) refer and transfer patients to hospitals with the capability to treat the needs of the patient involved.

"(F) LIMITATION ON APPLICATION TO CERTAIN CONVERTED FACILITIES.—The hospital was not converted from an ambulatory surgical center to a hospital on or after the date of enactment of this subsection.

"(G) PUBLICIZATION OF INFORMATION REPORTED.—The Secretary shall publish, and update on an annual basis, the information submitted by hospitals under paragraph (1) on the public Internet website of the Centers for Medicare & Medicaid Services.

"(H) EXCEPTION TO PROHIBITION ON EXPANSION OF FACILITY CAPACITY.—

"(i) PROCESS.—The Secretary shall establish and implement a process under

"(I) on any public website for the hospital; and

"(II) in any public advertising for the hospital.
which an applicable hospital (as defined in subparagraph (E)) may apply for an exception from the requirement under paragraph (1)(B).

(ii) OPPORTUNITY FOR COMMUNITY INPUT.—The process under clause (i) shall provide individuals and entities in the community in which the applicable hospital applying for an exception with the opportunity to provide input with respect to the application.

(iii) TIMING FOR IMPLEMENTATION.—The Secretary shall implement the process under clause (i) on August 1, 2011.

(iv) REGULATIONS.—Not later than July 1, 2011, the Secretary shall promulgate regulations to carry out the process under clause (i).

(b) FREQUENCY.—The process described in subparagraph (A) shall permit an applicable hospital to apply for an exception up to once every 2 years.

(C) PERMITTED INCREASE.—"(i) IN GENERAL.—Subject to clause (i) and subparagraph (D), an applicable hospital granted an exception under the process described in subparagraph (A) may increase the number of operating rooms, procedure rooms, and beds for which the applicable hospital is licensed above the baseline number of operating rooms, procedure rooms, and beds for which the applicable hospital is licensed under clause (i) to the extent that is greater than the average bed occupancy rate for the applicable hospital during that period, as estimated by Bureau of the Census.

(ii) FREQUENCY.—The process described in subparagraph (A) may only occur in facilities on the main campus of the applicable hospital.

(iii) BASELINE NUMBER OF OPERATING ROOMS, PROCEDURE ROOMS, AND BEDS.—In this paragraph, the term ‘baseline number of operating rooms, procedure rooms, and beds’ means the number of operating rooms, procedure rooms, and beds for which the applicable hospital is licensed under clause (i) to the extent that is greater than the average bed occupancy rate for the applicable hospital during that period, as estimated by Bureau of the Census.

(iv) ENSURING FACILITIES ON THE MAIN CAMPUS OF THE HOSPITAL.—Any increase in the number of operating rooms, procedure rooms, and beds for which an applicable hospital (as defined in paragraph (1)(B)) is licensed pursuant to this paragraph may only occur in facilities on the main campus of the applicable hospital.

(v) APPLICABLE HOSPITAL.—In this paragraph, the term ‘applicable hospital’ means a hospital to which the process described in paragraph (1)(B) is applicable.

(vi) PROCEDURE ROOMS.—In this subsection, the term ‘procedure rooms’ includes rooms in which catheterizations, angiographies, angiograms, and endoscopies are performed, except such term shall not include emergency rooms or departments (exclusive of rooms in which catheterizations, angiographies, angiograms, and endoscopies are performed).

(vii) PROCEDURE ROOM ACCESS.—The process described in subparagraph (A) shall permit an applicable hospital to apply for an exception up to once every 2 years.

(viii) PERIOD.—The process described in subparagraph (A) may only occur in facilities on the main campus of the applicable hospital.

(b) FREQUENCY.—The process described in subparagraph (A) may only occur in facilities on the main campus of the applicable hospital.

(c) PROCEDURE.—The process described in subparagraph (A) shall permit an applicable hospital to apply for an exception up to once every 2 years.

(d) TIMING FOR IMPLEMENTATION.—The Secretary shall implement the process under clause (i) on August 1, 2011.

(e) REGULATIONS.—Not later than July 1, 2011, the Secretary shall promulgate regulations to carry out the process under clause (i).

(f) FREQUENCY.—The process described in subparagraph (A) may only occur in facilities on the main campus of the applicable hospital.

(g) ENSURING FACILITIES ON THE MAIN CAMPUS OF THE HOSPITAL.—Any increase in the number of operating rooms, procedure rooms, and beds for which an applicable hospital (as defined in paragraph (1)(B)) is licensed pursuant to this paragraph may only occur in facilities on the main campus of the applicable hospital.

(h) APPLICABLE HOSPITAL.—In this paragraph, the term ‘applicable hospital’ means a hospital to which the process described in paragraph (1)(B) is applicable.

(i) PROCEDURE ROOMS.—In this subsection, the term ‘procedure rooms’ includes rooms in which catheterizations, angiographies, angiograms, and endoscopies are performed, except such term shall not include emergency rooms or departments (exclusive of rooms in which catheterizations, angiographies, angiograms, and endoscopies are performed).

(j) PROCEDURE ROOM ACCESS.—The process described in subparagraph (A) shall permit an applicable hospital to apply for an exception up to once every 2 years.

(k) PERIOD.—The process described in subparagraph (A) may only occur in facilities on the main campus of the applicable hospital.

(l) TIMING FOR IMPLEMENTATION.—The Secretary shall implement the process under clause (i) on August 1, 2011.

(m) REGULATIONS.—Not later than July 1, 2011, the Secretary shall promulgate regulations to carry out the process under clause (i).

(n) FREQUENCY.—The process described in subparagraph (A) may only occur in facilities on the main campus of the applicable hospital.

(o) ENSURING FACILITIES ON THE MAIN CAMPUS OF THE HOSPITAL.—Any increase in the number of operating rooms, procedure rooms, and beds for which an applicable hospital (as defined in paragraph (1)(B)) is licensed pursuant to this paragraph may only occur in facilities on the main campus of the applicable hospital.

(p) APPLICABLE HOSPITAL.—In this paragraph, the term ‘applicable hospital’ means a hospital to which the process described in paragraph (1)(B) is applicable.

(q) PROCEDURE ROOMS.—In this subsection, the term ‘procedure rooms’ includes rooms in which catheterizations, angiographies, angiograms, and endoscopies are performed, except such term shall not include emergency rooms or departments (exclusive of rooms in which catheterizations, angiographies, angiograms, and endoscopies are performed).

(r) PROCEDURE ROOM ACCESS.—The process described in subparagraph (A) shall permit an applicable hospital to apply for an exception up to once every 2 years.

(s) PERIOD.—The process described in subparagraph (A) may only occur in facilities on the main campus of the applicable hospital.

(t) TIMING FOR IMPLEMENTATION.—The Secretary shall implement the process under clause (i) on August 1, 2011.

(u) REGULATIONS.—Not later than July 1, 2011, the Secretary shall promulgate regulations to carry out the process under clause (i).

(v) FREQUENCY.—The process described in subparagraph (A) may only occur in facilities on the main campus of the applicable hospital.

(w) ENSURING FACILITIES ON THE MAIN CAMPUS OF THE HOSPITAL.—Any increase in the number of operating rooms, procedure rooms, and beds for which an applicable hospital (as defined in paragraph (1)(B)) is licensed pursuant to this paragraph may only occur in facilities on the main campus of the applicable hospital.

(x) APPLICABLE HOSPITAL.—In this paragraph, the term ‘applicable hospital’ means a hospital to which the process described in paragraph (1)(B) is applicable.

(y) PROCEDURE ROOMS.—In this subsection, the term ‘procedure rooms’ includes rooms in which catheterizations, angiographies, angiograms, and endoscopies are performed, except such term shall not include emergency rooms or departments (exclusive of rooms in which catheterizations, angiographies, angiograms, and endoscopies are performed).

(z) PROCEDURE ROOM ACCESS.—The process described in subparagraph (A) shall permit an applicable hospital to apply for an exception up to once every 2 years.

(aa) PERIOD.—The process described in subparagraph (A) may only occur in facilities on the main campus of the applicable hospital.

(bb) TIMING FOR IMPLEMENTATION.—The Secretary shall implement the process under clause (i) on August 1, 2011.

(cc) REGULATIONS.—Not later than July 1, 2011, the Secretary shall promulgate regulations to carry out the process under clause (i).

(dd) FREQUENCY.—The process described in subparagraph (A) may only occur in facilities on the main campus of the applicable hospital.
designated on behalf of a physician holding such an ownership or investment interest, including the information described in clauses (i) through (viii) of paragraph (1)(A), except that in applying such clauses, "physician" shall be substituted for "covered recipient" each place it appears.

"(D) Any other information regarding the ownership interest the Secretary determines appropriate.

"(b) PENALTIES FOR NONCOMPLIANCE.—

"(1)penalties.—

"(A) IN GENERAL.—Subject to subparagraph (B) except as provided in paragraph (2), any applicable manufacturer or applicable group purchasing organization that fails to submit information required under subsection (a) in a timely manner in accordance with rules or regulations promulgated to carry out such subsection is subject to a civil money penalty of not less than $1,000, but not more than $10,000, for each payment or other transfer of value or ownership or investment interest not reported as required under such subsection. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A as imposed and collected under that section.

"(B) LIMITATION.—The total amount of civil money penalties imposed under paragraph (A) with respect to each annual submission of information under subsection (a) by an applicable manufacturer or applicable group purchasing organization shall not exceed $150,000.

"(2) KNOWING FAILURE TO REPORT.—

"(A) IN GENERAL.—Subject to subparagraph (B), any applicable manufacturer or applicable group purchasing organization that knowingly fails to submit information required under subsection (a) in a timely manner in accordance with rules or regulations promulgated to carry out such subsection, shall be subject to a civil money penalty of not less than $10,000, but not more than $50,000, for each payment or other transfer of value or ownership or investment interest not reported as required under such subsection. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A as imposed and collected under that section.

"(B) LIMITATION.—The total amount of civil money penalties imposed under paragraph (A) with respect to each annual submission of information under subsection (a) by an applicable manufacturer or applicable group purchasing organization shall not exceed $1,000,000.

"(d) ANNUAL REPORTS AND RELATION TO STATE LAWS.—

"(1) ANNUAL REPORT TO CONGRESS.—Not later than April 1 of each year beginning in 2013, the Secretary shall submit to Congress a report that includes the following:

"(A) The information submitted under subsection (a) during the preceding year, aggregated for each applicable manufacturer and applicable group purchasing organization that submitted such information during such year.

"(B) A description of any enforcement actions taken to carry out this section, including any penalties imposed under subsection (b), during the preceding year.

"(2) ANNUAL REPORTS TO STATES.—Not later than September 30, 2013 and on June 30 of each calendar year thereafter, the Secretary shall submit to States a report that includes a summary of the information submitted under subsection (a) during the preceding year with respect to covered recipients in the State (except, in the case of information submitted with respect to a payment or other transfer of value described in subsection (c)(1)(E)(i), such information shall be included in the first report submitted to Congress on the date on which such information is made available to the public under such subsection).

"(B) A description of any enforcement action taken to carry out this section, including any penalties imposed under subsection (b), during the preceding year.

"(C) RELATION TO STATE LAWS.—

"(A) IN GENERAL.—In the case of a payment or other transfer of value provided by an applicable manufacturer that is received by a covered recipient (as defined in subsection (e)) on or after January 1, 2012, subject to subparagraph (B), the provisions of this section shall preempt any statute or regulation of a State or of a political subdivision of a State that requires an applicable manufacturer (as so defined) to disclose to or report, in any format, the type of information as described in subsection (a) regarding such payment or other transfer of value.

"(ii) of the Secretary to disclose such information to the Secretary under subsection (a), and

"(ii) for the Secretary to make such information submitted available to the public;

"(D) DEFINITION OF TERMS.—The procedures established under subparagraph (A) shall provide for the definition of terms (other than those terms defined in subsection (e)), as appropriate, for purposes of this section.

"(C) PUBLIC AVAILABILITY.—Except as provided in subparagraph (E), the procedures established under paragraph (A)(i) shall be available to the public on or after January 1, 2012, and on June 30 of each calendar year beginning thereafter, the information submitted under subsection (a) with respect to the preceding calendar year is made available to the public through an Internet website that is searchable and in a format that is easily aggregated and downloaded.

"(E) DELAYED PUBLICATION FOR PAYMENTS MADE PURSUANT TO PRODUCT RESEARCH OR DEVELOPMENT AGREEMENTS AND CLINICAL INVESTIGATIONS.—

"(i) IN GENERAL.—In the case of information submitted under subsection (a) with respect to a payment or other transfer of value made to or for an applicable manufacturer pursuant to a product research or development agreement for services furnished in connection with research on a potential new medical technology or a new application of an existing medical technology or the development of a new drug, device, biological, or medical supply, or by an applicable manufacturer in connection with a clinical investigation regarding a new drug, device, biological, or medical supply, the procedures established under subparagraph (A) shall provide that such information is made available to the public on the first date described in the matter preceding clause (i) in subparagraph (C) after the earlier of the following:

"(1) The date of the approval or clearance of the covered drug, device, biological, or medical supply by the Food and Drug Administration;

"(ii) Four calendar years after the date such payment or other transfer of value was made;

"(iii) CONFIDENTIALITY OF INFORMATION PRIOR TO PUBLICATION.—Information described in clause (i) shall be considered confidential and shall not be subject to disclosure under section 522 of title 5, United States Code, or any other similar Federal, State, or local law, until on or after the date on which the information is made available to the public under such clause.

"(ii) RELATION TO STATE LAWS.—

"(A) IN GENERAL.—In the case of a payment or other transfer of value described in subsection (e)(10)(B), except in the case of information described in clause (i) of such subsection.
‘(iii) by any person or entity other than an applicable manufacturer (as so defined) or a covered recipient (as defined in subsection (e)); or

(iv) to a Federal, State, or local governmental agency for public health surveillance, investigation, or other public health purposes or health oversight purposes.’

(2) Nothing in subparagraph (A) shall be construed to limit the discovery or admissibility of information described in such subparagraph in a criminal, civil, or administrative proceeding.

(4) CONSULTATION.—The Secretary shall consult with the Inspector General of the Department of Health and Human Services on the implementation of this section.

(e) DEFINITIONS.—In this section:

(1) APPLICABLE GROUP PURCHASING ORGANIZATION.—The term ‘applicable group purchasing organization’ means a group purchasing organization (as defined by the Secretary) that purchases, arranges for, or negotiates the purchase of a covered drug, device, biological, or medical supply which is operating in the United States, or in a territory, possession, or commonwealth of the United States.

(2) APPLICABLE MANUFACTURER.—The term ‘applicable manufacturer’ means a manufacturer, distributor, device, biological, or medical supply which is operating in the United States, or in a territory, possession, or commonwealth of the United States.

(3) CLINICAL INVESTIGATION.—The term ‘clinical investigation’ means any experi-

ment involving 1 or more human subjects, or the non-medical professional services of such individual is being referred from a person other than a person described in subparagraph (A)(i) and provide such individual with a written list of suppliers (as defined in section 1861(d)) who furnish such services in the area in which such individual resides.’

The amendment made by this section shall apply to services furnished on or after January 1, 2010.

SEC. 6004. PRESCRIPTION DRUG SAMPLE TRANS-PARENCY.

Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.), as amended by section 6002, is amended by inserting after section 1128D the following new section:

‘SEC. 1128FL. REPORTING OF INFORMATION RELATING TO DRUG SAMPLES.

(a) IN GENERAL.—Not later than April 1 of each year, the applicable manufacturer and authorized distributor of record of an applicable drug shall submit to the Secretary (in a form and manner specified by the Secretary) the following information with respect to the preceding year:

(1) In the case of a manufacturer or authorized distributor of record which makes distributions by mail or common carrier under subsection (d)(2) of section 503 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 335), the identity and quantity of drug samples requested and the identity and quantity of drug samples distributed under such subsection during that year, aggregation, and signature of the practitioner

(1) A transfer of anything of value to the covered recipient when the covered recipient is a licensed non-medical professional, a license non-medical professional, or an entity other than an applicable manufacturer, a distributing, or a pharmacist

(2) AUTHORIZED DISTRIBUTOR OF RECORD.—The term ‘authorized distributor of record’ means a manufacturer or distributor who owns or controls a pharmacy benefit management services organization referred to as a ‘PBM’ that manages pharmacy benefits management services on behalf of a person described in section 1128G the following new section:

(b) DEFINITIONS.—In this section:

(1) In the case of a manufacturer or authorized distributor of record which makes distributions by means other than mail or common carrier under subsection (d)(3) of section 503, the identity and quantity of drug samples requested and the identity and quantity of drug samples distributed under such subsection during that year, aggregation, and signature of the practitioner

(2) AUTHORIZED DISTRIBUTOR OF RECORD.—The term ‘authorized distributor of record’ means a manufacturer or distributor who owns or controls a pharmacy benefit management services organization referred to as a ‘PBM’ that manages pharmacy benefits management services on behalf of a person described in section 1128G the following new section:

(b) AUTHORIZED DISTRIBUTOR OF RECORD.—The term ‘authorized distributor of record’ means a manufacturer or distributor who owns or controls a pharmacy benefit management services organization referred to as a ‘PBM’ that manages pharmacy benefits management services on behalf of a person described in section 1128G the following new section:

(1) A transfer of anything of value to the covered recipient when the covered recipient is a licensed non-medical professional, a license non-medical professional, or an entity other than an applicable manufacturer, a distributing, or a pharmacist

(2) AUTHORIZED DISTRIBUTOR OF RECORD.—The term ‘authorized distributor of record’ means a manufacturer or distributor who owns or controls a pharmacy benefit management services organization referred to as a ‘PBM’ that manages pharmacy benefits management services on behalf of a person described in section 1128G the following new section:

‘SEC. 1150A. PHARMACY BENEFIT MANAGERS TRANSPARENCY REQUIREMENTS.

(a) PROVIDING ACCURATE INFORMATION.—A pharmacy benefit manager of a health benefits plan or any entity that provides pharmacy benefits management services on behalf of a health benefits plan (in this section referred to as a ‘PBM’) shall provide accurate prescription drug coverage under a contract with
Subtitle B—Nursing Home Transparency and Improvement

PART I—IMPROVING TRANSPARENCY OF INFORMATION

SEC. 6101. REQUIRED DISCLOSURE OF OWNERSHIP AND ADDITIONAL DISCLOSABLE PARTIES INFORMATION.

(a) In General.—Section 1121 of the Social Security Act (42 U.S.C. 1320b-3) is amended by adding at the end the following new subsection:

"(c) REQUIRED DISCLOSURE OF OWNERSHIP AND ADDITIONAL DISCLOSABLE PARTIES INFORMATION.—

"(1) DISCLOSURE.—A facility shall have the information described in paragraph (2) available—

"(A) during the period beginning on the date of the enactment of this subsection and ending on the date such information is made available to the public under section 6101(b) of the Patient Protection and Affordable Care Act for submission to the Secretary, the Inspector General of the Department of Health and Human Services, the State in which the facility is located, and the State long-term care ombudsman in the case where the Secretary, the Inspector General, the State, or the State long-term care ombudsman requests such information; and

"(B) beginning on the effective date of the final regulations promulgated under paragraph (3)(A), for reporting such information in accordance with such final regulations.

Nothing in subparagraph (A) shall be construed as authorizing a facility to disclose or delete information described in such subparagraph after the effective date of the final regulations promulgated under paragraph (3)(A).

"(2) INFORMATION DESCRIBED.—

"(A) IN GENERAL.—The following information is described in this paragraph:

"(i) The organizational structure of each additional disclosable party of the facility, in the case of each facility, including the name, title, and period of service of each such person or entity;

"(ii) each person or entity who is an officer, director, managing employee, trustee, or managing employee of the facility, including the name, title, and period of service of each such person or entity; and

"(III) each person or entity who is an additional disclosable party of the facility.

"(iii) The organizational structure of each additional disclosable party of the facility, including a description of each such additional disclosable party to the facility and to one another.

"(B) SPECIAL HULS WHERE INFORMATION IS ALREADY REPORTED OR SUBMITTED.—To the extent that information reported by a facility to the Internal Revenue Service on Form 990, information submitted by a facility to the Securities and Exchange Commission, or information otherwise submitted to the Secretary or any other Federal agency contains the information described in clauses (i), (ii), or (III) of subparagraph (A), such additional party to the facility may provide such Form or such information submitted to meet the requirements of paragraph (1).

"(C) SPECIAL HULS.—In applying subparagraph (A)(i) and (ii):

"(i) with respect to subsections (a) and (b), ‘ownership or control interest’ shall include direct or indirect control of such interests in intermediate entities; and

"(ii) subsection (a)(3)(A)(ii) shall include the owner of a whole or part interest in any property or assets that is held in trust for the trust; and

"(iii) an individual, contact information for the individual; and

of the interest equal to or exceeds 5 percent of the total property or assets of the entire.
cordance with such final regulations available to the public in accordance with procedures established by the Secretary.

(c) CONFORMING AMENDMENTS.—

(1) IN GENERAL.—Section 1128I(d)(1) of the Social Security Act (42 U.S.C. 1396d(l)) is amended by striking subparagraph (B) and redesignating subparagraph (C) as subparagraph (B). (2) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on the date on which the Secretary makes the information described in subparagraph (b)(1) available to the public under such subsection.

SEC. 6102. ACCOUNTABILITY REQUIREMENTS FOR SKILLED NURSING FACILITIES AND HOME CARE FACILITIES.

Part A of title XI of the Social Security Act (42 U.S.C. 1311 et seq.), as amended by sections 6002 and 6004, is amended by inserting after section 1128B the following new section:

SEC. 1128B. ACCOUNTABILITY REQUIREMENTS FOR SKILLED NURSING FACILITIES AND HOME CARE FACILITIES.

(a) DEFINITION OF FACILITY.—In this section, the term ‘facility’ means—

(1) a skilled nursing facility (as defined in section 1315(a)); or

(2) a nursing facility (as defined in section 1919(a)).

(b) EFFECTIVE COMPLIANCE AND ETHICS PROGRAMS FOR FACILITIES.—

(1) REQUIREMENT.—On or after the date that is 36 months after the date of the enactment of this section, a facility shall, with respect to the entity that operates the facility, establish written policies defining the standards and procedures to be followed by its employees and other agents, such as by requiring participation in training programs or by disseminating publications that explain in a practical manner what steps to take for detecting, reporting, and responding to improper activity.

(2) DEVELOPMENT OF REGULATIONS.—

(A) IN GENERAL.—Not later than the date that is 2 years after such date of the enactment of such regulations, the Secretary, working jointly with the Inspector General of the Department of Health and Human Services, shall promulgate regulations for an effective compliance and ethics program for operating organizations, which may include a model compliance program.

(B) DESIGN OF REGULATIONS.—Such regulations with respect to specific elements or formality of a program shall, in the case of an organization that operates 5 or more facilities, vary with the size of the organization, not be required for operating organizations that have a more formal program and include established written policies defining the standards and procedures to be followed by its employees and other agents.

(C) EVALUATION.—Not later than 3 years after the date on which final regulations are promulgated under this paragraph, the Secretary shall complete an evaluation of the compliance and ethics programs required to be established under subsection (a). Such evaluation shall determine if such programs led to increased or actual changes in the behavior of the organization, not including any changes in behavior provided for in other laws.

(d) REQUIRED COMPONENTS OF PROGRAM.—The required components of a compliance and ethics program of an operating organization are the following:

(1) The organization must have established a compliance and ethics program, or the school or facility, school, or program for which the facility is operated, has an ethics program and established all required components.

(2) The school or facility, school, or program for which the facility is operated, has an ethics program and established all required components.

(e) REGULATIONS.—The regulations shall ensure that the Department of Health and Human Services establishes, as part of the information provided for comparison of nursing homes on the official Internet website of the Federal Government for Medicare beneficiaries (commonly referred to as the ‘Nursing Home Compare’ Medicare website) (or a successor website), the following information in a manner that is consistent with the Uniform Data System for Medical Care (or successor system), and that is clearly understandable to consumers of long-term care services and allows such consumers to compare differences in staffing between facilities and State and national averages for the facilities.

(f) Staffing data for each facility (including resident census data and data on the hours of care provided per resident per day) based on data submitted under section 1128I(g), including information on staffing mix and tenure, that is clearly understandable to consumers of long-term care services and allows such consumers to compare differences in staffing between facilities and State and national averages for the facilities. Such format shall include—

(1) concise explanations of how to interpret the data, such as a plain English explanation of data reflecting ‘nursing home staff hours per resident day’;

(2) differences in types of staff (such as those associated with different categories of staffing;

(3) the relationship between nurse staffing levels and quality of care; and

(g) Information on staffing levels for each facility mix.

(h) Links to State Internet websites with information regarding State survey and certification programs, links to Form 2567 State inspection reports (or a successor form) on such websites, information to guide consumers in how to understand such reports, and the facility plan of correction or other response to such report. Any such links shall be posted on a timely basis.

(i) The standards and requirements shall be developed under section 1128I(f), including explanatory material on what complaint forms are, how they are used, and how to file a complaint.

(j) The standards and requirements shall be developed under section 1128I(f), including explanatory material on what complaint forms are, how they are used, and how to file a complaint.

(k) The standards and requirements shall be developed under section 1128I(f), including explanatory material on what complaint forms are, how they are used, and how to file a complaint.

(l) The standards and requirements shall be developed under section 1128I(f), including explanatory material on what complaint forms are, how they are used, and how to file a complaint.

(m) The standards and requirements shall be developed under section 1128I(f), including explanatory material on what complaint forms are, how they are used, and how to file a complaint.

(n) The standards and requirements shall be developed under section 1128I(f), including explanatory material on what complaint forms are, how they are used, and how to file a complaint.
(iv) Summary information on the number, type, severity, and outcome of substantiated complaints.

(v) The number of adjudicated instances of criminal actions as having been taken by a facility or the employees of a facility—

‘‘(1) that were committed inside the facility;

‘‘(2) with respect to such instances of violations or crimes committed inside of the facility that were the violations or crimes of abuse, neglect, and exploitation, criminal sexual conduct, or other violations or crimes that resulted in serious bodily injury; and

‘‘(3) the number of civil monetary penalties assessed against the facility, employees, contractors, and other agents.

(b) DUE DATE.—The Department of Health and Human Services shall update the information provided under paragraph (A) to reflect any changes made through the end of the following new paragraph:

‘‘(1) NURSING HOME COMPARE WEBSITE.—

‘‘(i) IN GENERAL.—The Secretary shall ensure that the Department of Health and Human Services makes available to the public under subparagraph (A) and provided on the Nursing Home Compare Medicare website the following information:

‘‘(II) information that is made available under section 1819(f) of the Social Security Act (42 U.S.C. 1396r) is amended—

‘‘(i) by redesignating subparagraph (i) as subparagraph (j); and

‘‘(ii) by inserting after subparagraph (h) the following new subsection:

‘‘(A) IN GENERAL.—The Secretary shall conduct a special focus facility program for enforcement of requirements for skilled nursing facilities that the Secretary has identified as having substantially failed to meet applicable requirements of this Act.

‘‘(B) PERIODIC SURVEYS.—Under such program the Secretary shall conduct surveys of such facility in the program not less than once every 6 months.

‘‘(c) NURSING FACILITIES.—

‘‘(1) IN GENERAL.—Section 1919 of the Social Security Act (42 U.S.C. 1396r) is amended—

‘‘(A) by redesignating subsection (i) as subparagraph (j); and

‘‘(B) by inserting after subsection (h) the following new subsection:

‘‘(1) NURSING HOME COMPARE WEBSITE.—

‘‘(i) INCLUSION OF ADDITIONAL INFORMATION.—

(A) IN GENERAL.—The Secretary shall ensure that the Department of Health and Human Services makes available to the public under subparagraph (A) and provided on the Nursing Home Compare Medicare website as expeditiously as practicable the following additional information:

‘‘(II) differences in types of staff (such as training associated with different categories of staff);

‘‘(III) the relationship between nurse staffing levels and outcomes;

‘‘(IV) an explanation that appropriate staffing levels vary based on patient case mix.

‘‘(2) DUE DATE.—The amendment made by this paragraph shall take effect 1 year after the date of the enactment of this Act.

‘‘(d) SPECIAL FOCUS FACILITY PROGRAM .—Section 1919(a)(10) of the Social Security Act (42 U.S.C. 1396r(a)(10)) is amended by adding at the end the following new paragraph:

‘‘(1) NURSING HOME COMPARE WEBSITE.—

‘‘(i) IN GENERAL.—Except as provided in clause (ii), the Secretary shall ensure that the information described in subparagraph (A) is included on such website (or a successor website) not later than 1 year after the date of the enactment of this subsection; and

‘‘(ii) EXCEPTION.—The Secretary shall ensure that the information described in subparagraph (A) is included on such website (or a successor website) not later than the date on which the requirements under section 1128G(i) are implemented.

‘‘(e) REVIEW AND MODIFICATION OF WEBSITE.—

(A) IN GENERAL.—The Secretary shall establish policies for—

‘‘(i) to review the accuracy, clarity of presentation, timeliness, and comprehensiveness of information reported on such website as of the day before the date of the enactment of this subsection; and

‘‘(ii) not later than 1 year after the date of the enactment of this subsection, to modify or revamp such website in accordance with the review conducted under clause (i).

(B) CONSULTATION.—In conducting the review under subparagraph (A)(i), the Secretary shall consult with—

‘‘(1) State long-term care ombudsman programs;

‘‘(2) consumer advocacy groups;

‘‘(iii) provider stakeholder groups;

‘‘(iv) skilled nursing facility employees and their representatives; and

‘‘(v) any other representatives of programs or groups the Secretary determines appropriate.

‘‘(f) TIMELINESS OF SUBMISSION OF SURVEY AND CERTIFICATION INFORMATION.—

(A) IN GENERAL.—Section 1919(g)(5) of the Social Security Act (42 U.S.C. 1396r(g)(5)) is amended by adding at the end the following new paragraph:

(B) SUBMISSION OF SURVEY AND CERTIFICATION INFORMATION TO THE SECRETARY.—In order to improve the timeliness of information made available to the public under subparagraph (A) and provided on the Nursing Home Compare Medicare website under section (j), each State shall submit information respecting any survey or certification made respecting a nursing facility (including any enforcement actions taken by the State) to the Secretary not later than the date on which the State sends such information to the facility. The Secretary shall use the information submitted under the preceding sentence to update the information provided on the Nursing Home Compare Medicare website as expeditiously as practicable but not less frequently than quarterly.

(B) EFFECTIVE DATE.—The amendment made by this paragraph shall take effect 1 year after the date of the enactment of this Act.

‘‘(g) SPECIAL FOCUS FACILITY PROGRAM .—Section 1919(f) of the Social Security Act (42 U.S.C. 1396r(f)) is amended by adding at the end of the following new paragraph:

(A) IN GENERAL.—The Secretary shall conduct a special focus facility program for enforcement of requirements for nursing facilities that the Secretary has identified as having substantially failed to meet applicable requirements of this Act.

(B) PERIODIC SURVEYS.—Under such program the Secretary shall conduct surveys of such facility in the program at least 1 year after the date of the enactment of this subsection.

‘‘(h) EXCEPTION.—The Secretary shall ensure that the information described in subparagraph (A) is included on such website (or a successor website) not later than the date on which the requirements under section 1128G(i) are implemented.
(C) AVAILABILITY OF SURVEY, CERTIFICATION, AND COMPLAINT INVESTIGATION REPORTS.—A skilled nursing facility must—  
(i) have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years available for any individual to review upon request, and  
(ii) make the availability of such reports in areas of the facility that are prominent and accessible to the public. The facility shall not make available under clause (i) any information about complainants or residents.”.  
(2) NURSING FACILITIES.—Section 1919(d)(1) of the Social Security Act (42 U.S.C. 1396r(d)(1)), as amended by section 6101, is amended by adding at the end the following new subparagraph:  
“(v) AVAILABILITY OF SURVEY, CERTIFICATION, AND COMPLAINT INVESTIGATION REPORTS.—A nursing facility must—  
(i) have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years available for any individual to review upon request, and  
(ii) make the availability of such reports in areas of the facility that are prominent and accessible to the public. The facility shall not make available under clause (i) any information about complainants or residents.”.  
(3) EFFECTIVE DATE.—The amendments made by this subsection shall take effect 1 year after the date of the enactment of this Act.

(d) GUIDANCE TO STATES ON FORM 2567 STATE INSPECTION REPORTS AND COMPLAINT INVESTIGATION REPORTS.—

(1) GUIDANCE.—The Secretary of Health and Human Services (in this subtitle referred to as the Secretary) shall provide guidance to States on how States can establish electronic links to Form 2567 State inspection reports (or a successor form), complaint investigation reports, and a facility’s plan of correction or other response to such Form 2567 State inspection reports (or a successor form, on the Internet) that establishes a website providing useful information on skilled nursing facilities and all nursing facilities in the State, including for each facility, Form 2567 State inspection reports (or a successor form) and complaint investigation reports that the Secretary determines appropriate, shall take the expenditures listed on cost reports, as modified under paragraph (1), submitted by skilled nursing facilities and categorize such expenditures, regardless of any source of payment for such expenditures, for each skilled nursing facility into the following functional accounts on an annual basis:

(1) Spending on direct care services (including nursing, therapy, and medical services).
(2) Spending on indirect care (including housekeeping and dietary services).
(3) Capital assets (including building and land costs).
(4) Administrative services costs.
(5) Aítulo AVAILABILITY OF INFORMATION SUBMITTED.—The Secretary shall establish procedures to make information on expenditures submitted under this subsection readily available to interested parties upon request, subject to such requirements as the Secretary may specify under the procedures established under this paragraph.

SECTION 6105. STANDARDIZED COMPLAINT FORM.

(a) IN GENERAL.—Section 1128I of the Social Security Act, as added and amended by this Act, is amended by adding at the end the following new subsection:

“(2) COMPLAINT FORMS AND RESOLUTION PROCESSES.—  
(A) COMPLAINT FORMS.—The State must make the standardized complaint form described under paragraph (1) available to the public.  
(B) COMPLAINT RESOLUTION PROCESS.—The State must establish a complaint resolution process in order to ensure that the legal representative of a resident or other responsible party is not denied access to such resident or otherwise retaliated against if they have complained about the quality of care provided by the facility or other issues relating to the facility. Such complaint resolution process shall include—  
(i) procedures to assure accurate tracking of complaints received, including notification to the complainant that a complaint has been received;  
(ii) procedures to determine the likely source and root cause of the complaint, and for the investigation of the complaint; and  
(iii) deadlines for responding to a complaint and for notifying the complainant of the outcome of the investigation.

(B) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed as preventing a resident of a facility (or a person acting on behalf of a resident) from submitting a complaint in a manner or format other than by using the standardized complaint form developed under paragraph (1) (including submitting a complaint orally).”.

(b) EFFECTIVE DATE.—The amendment made by this section shall take effect 1 year after the date of the enactment of this Act.
“(4) include information on employee turnover and tenure and on the hours of care provided by each category of certified employees referenced in paragraph (1) per resident per day.

Nothing in this subsection shall be construed as preventing the Secretary from requiring submission of such information with respect to personnel such as nursing staff, before other categories of certified employees. Information under this subsection with respect to agency and contract staff shall be kept separate from information on employee staffing.”.

SEC. 6107. GAO STUDY AND REPORT ON FIVE-STAR QUALITY RATING SYSTEM.

(a) Study.—The Secretary of Health and Human Services in consultation with the Comptroller General of the United States (in this section referred to as the “Comptroller General”) shall conduct a study on the Five-Star Quality Rating System for nursing homes of the Centers for Medicare & Medicaid Services. Such study shall include an analysis of—

(1) how such system is being implemented;
(2) any problems associated with such system or its implementation; and
(3) how such system could be improved.

(b) Report.—Not later than 2 years after the date of enactment of this Act, the Comptroller General shall submit to Congress a report containing the results of the study conducted under subsection (a), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

PART II—TARGETING ENFORCEMENT

SEC. 6110. CIVIL MONEY PENALTIES.

(a) Skilled Nursing Facilities.—

(1) In general.—Section 1819(h)(2)(B)(ii) of the Social Security Act (42 U.S.C. 1395i-3(b)(2)(II)) is amended—

(A) by striking “PENALTIES.—The Secretary’’ and inserting “PENALTIES.—”;

(B) in the case where such appeals are unsuccessful, may provide that a portion of such amounts collected is kept in such account pending the resolution of any subsequent appeals.

(c) in the case where the facility successfully appeals the penalty, may provide for the return of such amounts collected (plus interest) to the facility; and

(2) how such appeals are unsuccessful, may provide that such portion of such amounts collected may be used to support activities that benefit residents, including assistance to support and protect residents of a facility that closes (voluntary or involuntary), is decertified (including offsetting costs of relocating residents to other facilities or another facility), projects that support resident and family councils and other consumer involvement in ensuring quality care in facilities, and facility improvement initiatives approved by the Secretary (including joint training of facility staff and surveyors, technical assistance for facilities implementing quality assurance programs, the appointment of temporary management firms, and other activities approved by the Secretary).

(b) Reporting.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall—

(1) conduct the demonstration project under this section not later than 1 year after the date of the enactment of this Act.

(2) CONFORMING AMENDMENT.—Section 1919(b)(5)(B) of the Social Security Act (42 U.S.C. 1396n(b)(5)(B)) is amended by inserting “(ii)(IV),” after “(i),”.

(c) National Independent Monitor Demonstration Project.

(1) Establishment.—The Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall conduct a demonstration project to develop, test, and implement an independent monitor program to oversee interstate and large intrastate chains of skilled nursing facilities and nursing facilities.

(2) Selection.—The Secretary shall select chains of skilled nursing facilities and nursing facilities that submit an application to the Secretary.

(3) Duration.—The Secretary shall conduct the demonstration project under this section for a 2-year period.

(4) Implementation.—The Secretary shall implement the demonstration project under this section not later than 2 years after the date of the enactment of this Act.

(5) Requirements.—The Secretary shall evaluate chains selected to participate in the demonstration project based on criteria selected by the Secretary, including where evidence suggests that a
(4) SECRETARY.—The term “Secretary” means the Secretary of Health and Human Services, acting through the Assistant Secretary for Planning and Evaluation.

(5) Skilled Nursing Facility.—The term “skilled nursing facility” has the meaning given such term in section 1819(a) of the Social Security Act (42 U.S.C. 1396r(a)).

(1) EVALUATION AND REPORT.—

(a) In General.—The Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall evaluate the demonstration project conducted under subsection (b).

(b) REPORT.—Not later than 180 days after the completion of the demonstration project under this section, the Secretary shall submit to the independent monitor a report containing the results of the evaluation conducted under paragraph (1), together with recommendations:

(1) as to whether the independent monitor should be established on a permanent basis;

(2) if the Secretary recommends that such program be so established, on appropriate procedures and mechanisms for such establishment; and

(3) for such legislation and administrative action as the Secretary determines appropriate.

SEC. 6113. NOTIFICATION OF FACILITY CLOSURE.

(a) In General.—

(1) NURSING FACILITY.—The term “nursing facility” has the meaning given such term in section 1819(a) of the Social Security Act (42 U.S.C. 1396r(a)).

(2) SKILLED NURSING FACILITY.—The term “skilled nursing facility” has the meaning given such term in section 1819(a) of the Social Security Act (42 U.S.C. 1396r(a)).

(3) RESIDENTS.—The term “resident” means any individual who is a resident of a facility.

(4) SECRETARY.—The term “Secretary” means the Secretary of Health and Human Services.

(b) REQUIREMENTS.—

(1) REQUIREMENT.—

(A) ANNUAL NOTIFICATION.—The Secretary shall require each nursing facility to annually notify the Secretary, the State, and the legal representatives of the residents, in writing, of any major change in the following:

(i) the management of the facility;

(ii) the quality of care provided to residents;

(iii) any other matter that the Secretary determines appropriate.

(B) TERMINATION.—The Secretary shall terminate a nursing facility under this subsection if the Secretary determines that the facility is not providing quality care to its residents.

(c) AMENDMENTS.—

(1) IN GENERAL.—Section 1919(a) of the Social Security Act (42 U.S.C. 1396r(a)) is amended by striking “1 year after the date of the enactment of this Act” and inserting “1 year after the date of the enactment of this Act, and 3 years thereafter.”

(2) EFFECTIVE DATE.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act.

SEC. 6114. NATIONAL DEMONSTRATION PROJECTS ON CULTURE CHANGE AND USE OF INFORMATION TECHNOLOGY IN NURSING HOMES.

(a) IN GENERAL.—

(1) NURSING FACILITY.—The term “nursing facility” has the meaning given such term in section 1819(a) of the Social Security Act (42 U.S.C. 1396r(a)).

(2) SKILLED NURSING FACILITY.—The term “skilled nursing facility” has the meaning given such term in section 1819(a) of the Social Security Act (42 U.S.C. 1396r(a)).

(b) REQUIREMENTS.—

(1) REQUIREMENT.—The Secretary shall require each nursing facility to annually notify the Secretary, the State, and the legal representatives of the residents, in writing, of any major change in the following:

(i) the management of the facility;

(ii) the quality of care provided to residents;

(iii) any other matter that the Secretary determines appropriate.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act.

SEC. 6115. PROJECTS ON CULTURE CHANGE.

(a) IN GENERAL.—

(1) NURSING FACILITY.—The term “nursing facility” has the meaning given such term in section 1819(a) of the Social Security Act (42 U.S.C. 1396r(a)).

(2) SKILLED NURSING FACILITY.—The term “skilled nursing facility” has the meaning given such term in section 1819(a) of the Social Security Act (42 U.S.C. 1396r(a)).

(3) RESIDENTS.—The term “resident” means any individual who is a resident of a facility.

(4) SECRETARY.—The term “Secretary” means the Secretary of Health and Human Services.

(b) REQUIREMENTS.—

(1) REQUIREMENT.—

(A) ANNUAL NOTIFICATION.—The Secretary shall require each nursing facility to annually notify the Secretary, the State, and the legal representatives of the residents, in writing, of any major change in the following:

(i) the management of the facility;

(ii) the quality of care provided to residents;

(iii) any other matter that the Secretary determines appropriate.

(B) TERMINATION.—The Secretary shall terminate a nursing facility under this subsection if the Secretary determines that the facility is not providing quality care to its residents.

(c) AMENDMENTS.—

(1) IN GENERAL.—Section 1919(a) of the Social Security Act (42 U.S.C. 1396r(a)) is amended by striking “1 year after the date of the enactment of this Act” and inserting “1 year after the date of the enactment of this Act, and 3 years thereafter.”

(2) EFFECTIVE DATE.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act.

SEC. 6116. AUTHORIZATION OF APPROPRIATIONS.

(a) IN GENERAL.—

(1) NURSING FACILITY.—The term “nursing facility” has the meaning given such term in section 1819(a) of the Social Security Act (42 U.S.C. 1396r(a)).

(2) SKILLED NURSING FACILITY.—The term “skilled nursing facility” has the meaning given such term in section 1819(a) of the Social Security Act (42 U.S.C. 1396r(a)).

(b) REQUIREMENTS.—

(1) REQUIREMENT.—The Secretary shall require each nursing facility to annually notify the Secretary, the State, and the legal representatives of the residents, in writing, of any major change in the following:

(i) the management of the facility;

(ii) the quality of care provided to residents;

(iii) any other matter that the Secretary determines appropriate.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act.

SEC. 6117. PROJECTS ON CULTURE CHANGE AND USE OF INFORMATION TECHNOLOGY IN NURSING HOMES.

(a) IN GENERAL.—

(1) NURSING FACILITY.—The term “nursing facility” has the meaning given such term in section 1819(a) of the Social Security Act (42 U.S.C. 1396r(a)).

(2) SKILLED NURSING FACILITY.—The term “skilled nursing facility” has the meaning given such term in section 1819(a) of the Social Security Act (42 U.S.C. 1396r(a)).

(3) RESIDENTS.—The term “resident” means any individual who is a resident of a facility.

(4) SECRETARY.—The term “Secretary” means the Secretary of Health and Human Services.

(b) REQUIREMENTS.—

(1) REQUIREMENT.—The Secretary shall require each nursing facility to annually notify the Secretary, the State, and the legal representatives of the residents, in writing, of any major change in the following:

(i) the management of the facility;

(ii) the quality of care provided to residents;

(iii) any other matter that the Secretary determines appropriate.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act.

SEC. 6118. PROJECTS ON CULTURE CHANGE.

(a) IN GENERAL.—

(1) NURSING FACILITY.—The term “nursing facility” has the meaning given such term in section 1819(a) of the Social Security Act (42 U.S.C. 1396r(a)).

(2) SKILLED NURSING FACILITY.—The term “skilled nursing facility” has the meaning given such term in section 1819(a) of the Social Security Act (42 U.S.C. 1396r(a)).

(3) RESIDENTS.—The term “resident” means any individual who is a resident of a facility.

(4) SECRETARY.—The term “Secretary” means the Secretary of Health and Human Services.

(b) REQUIREMENTS.—

(1) REQUIREMENT.—The Secretary shall require each nursing facility to annually notify the Secretary, the State, and the legal representatives of the residents, in writing, of any major change in the following:

(i) the management of the facility;

(ii) the quality of care provided to residents;

(iii) any other matter that the Secretary determines appropriate.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act.
the Secretary shall submit to Congress a report on such project, together with recommendations for such legislation and administrative action as the Secretary determines appropriate, in the case of ongoing training, disease management training, and patient abuse prevention training, before such time as the Secretary may specify.

PART III—IMPROVING STAFF TRAINING

SEC. 6212. DEMENTIA AND ABUSE PREVENTION TRAINING

(a) SKILLFUL SERVICING FACILITIES.—In general.—Section 1819(b)(2)(A)(i)(I) of the Social Security Act (42 U.S.C. 1396r-3(f)(2)(A)(i)(I)) is amended by inserting "including, in the case of initial training and, if the Secretary determines appropriate, in the case of ongoing training, dementia management training, and patient abuse prevention training" before "(1)".

(b) NURSING FACILITIES.—In general.—Section 1919(b)(2)(A)(i)(I) of the Social Security Act (42 U.S.C. 1396n-3(f)(2)(A)(i)(I)) is amended by inserting "including, in the case of initial training and, if the Secretary determines appropriate, in the case of ongoing training, dementia management training, and patient abuse prevention training" before "(1)".

(2) CLARIFICATION OF DEFINITION OF NURSE AIDE.—Section 1819(b)(5)(F) of the Social Security Act (42 U.S.C. 1396l-3(b)(5)(F)) is amended by adding at the end the following flush sentence: "Such term includes an individual who provides such services through an agency or under a contract with the facility.".

(c) EFFECTIVE DATE.—The amendments made by this subsection shall take effect 1 year after the date of the enactment of this Act.

Subtitle C—Nациональный программе для федеральных и государственных фондов по профессиональной подготовке работников мойской сферы (включая водительские и носители документов)

SEC. 6201. NATIONWIDE PROGRAM FOR NATIONAL AND STATE BACKGROUND CHECKS ON DIRECT PATIENT ACCESS EMPLOYEES OF LONG-TERM CARE FACILITIES AND PROVIDERS.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall establish a program to identify efficient, effective, and economically sound methods that reduce duplicative fingerprinting, including providing for the development of "rap back" capability by the States such that, if a direct patient access employee of a long-term care facility or provider is convicted of a crime following the initial criminal history background check conducted with respect to such employee, and the employee's fingerprints match the prints on file with the Federal bureau of investigation and are verified by the department, the department will immediately inform the State and the State will immediately inform the long-term care facility or provider which employs the direct patient access employee of such conviction; and

(C) require that criminal history background checks conducted with respect to the costs to be incurred by the provider or provider (or the designated agent of the provider) obtain the information obtained in a background check of such records; and

(B) certain previously participating states.—The Secretary shall enter into agreements with each State—(i) that the Secretary has entered into an agreement with the Government of the United States in accordance with the requirements of this section;

(ii) that agrees to conduct background checks under the nationwide program on a Statewide basis; and

(iii) that submits an application to the Secretary containing such information and at such time as the Secretary may specify.

(b) REQUIRED FINGERPRINT CHECK AS PART OF CRIMINAL HISTORY BACKGROUND CHECK.—The procedures established under subsection (b)(1) of such section 307 shall—(A) require that the long-term care facility or provider (or the designated agent of the long-term care facility or provider) obtain the information obtained in a background check conducted with respect to such employee, and the employee's fingerprints match the prints on file with the State law enforcement agency as the Secretary determines appropriate, efficient, and effective that utilize a such background check and neglect registries and databases, including the abuse and neglect registries of another State in the case where a prospective direct patient access employee has been convicted of a crime following the initial criminal history background check conducted regarding a prospective direct patient access employee to determine whether the employee has any conviction for a relevant crime; and

(V) determine which individuals are direct patient access employees (as defined in paragraph (6)(B)) for purposes of the nationwide program;

(vi) determine which individuals are direct patient access employees (as defined in paragraph (6)(B)) for purposes of the nationwide program; and

(vii) in the case of an employee with a conviction for a relevant crime that is subject to reporting under section 1128B of the Social Security Act (42 U.S.C. 1320a-7b), report the existence of such conviction to the database established under that section; and

(vii) in the case of an employee with a conviction for a relevant crime that is subject to reporting under section 1128B of the Social Security Act (42 U.S.C. 1320a-7b), report the existence of such conviction to the database established under that section;
or through donations from public or private entities a particular amount of non-Federal contributions, as a condition of receiving the Federal match under clause (i).

(ii) The payment amount to each State that the Secretary enters into an agreement with under paragraph (1)(A) shall be 3 times the amount that the State guarantees to make available under clause (i), except that in no case may the payment amount exceed $3,000,000.

(B) PREVIOUSLY PARTICIPATING STATES.—(i) GENERAL.—In the case of a State that elected to participate in the Act under section 1861(dd)(1) of such Act (42 U.S.C. 1395x(d)(1)) prior to November 20, 2009, the payment amount to the State shall be 2 times the amount that the State guarantees to make available under clause (i), except that in no case may the payment amount exceed $1,500,000.

(ii) FEDERAL MATCH.—The payment amount to each State that the Secretary enters into an agreement with under paragraph (1)(B) shall be 3 times the amount that the Secretary guarantees to make available under clause (i), except that in no case may the payment amount exceed $1,500,000.

(C) DEFINITIONS.—Under the nationwide program:

(1) CONVICTION FOR A RELEVANT CRIME.—The term ‘conviction for a relevant crime’ means any Federal or State criminal conviction from which the person may not subsequently be pardoned.

(2) DISQUALIFYING INFORMATION.—The term ‘disqualifying information’ means any substantiated finding of a patient or resident abuse.

(3) FINDING OF PATIENT OR RESIDENT ABUSE.—The term ‘finding of patient or resident abuse’ means any substantiated finding by a State agency under section 1819(g) and 1919(g) of the Social Security Act (42 U.S.C. 1395xw(d)(1) or 1395l(d)(1)) of the Social Security Act (42 U.S.C. 1395x(dd)(1)) or 1395l(dd)(1)) or a Federal agency that a direct patient access employee has committed—

(i) an act of patient or resident abuse or neglect; or

(ii) any other offenses described in section 1128(a) of the Social Security Act (42 U.S.C. 1320a-7).

(4) VOLUNTEER.—The term ‘volunteer’ means a person who provides services for a hospital, or other facility, or provider through employment or through a contract with such facility or provider and has duties that do not involve a direct one-on-one contact with a patient or resident of a long-term care facility or provider.

(5) LONG-TERM CARE FACILITY OR PROVIDER.—The term ‘long-term care facility or provider’ means a hospital, or any other facility, or provider through employment or through a contract with such facility or provider and has duties that do not involve a direct one-on-one contact with a patient or resident of a long-term care facility or provider.

(iv) PROVIDER OF HOSPICE CARE.—The term ‘provider of hospice care’ means any hospice care provider.

(v) PROVIDER OF ADMISSIONS.—The term ‘provider of admissions’ means any admissions staff.

(vi) PROVIDER OF LONG-TERM CARE SERVICES.—The term ‘provider of long-term care services’ means any provider of long-term care services.

(vii) PROVIDER OF PRIMARY CARE SERVICES.—The term ‘provider of primary care services’ means any primary care provider.

3(3) FUNDING OF COMPARATIVE CLINICAL EFFECTIVENESS RESEARCH.—

(A) IN GENERAL.—The term ‘comparative clinical effectiveness research’ means research evaluating and comparing health outcomes and the clinical effectiveness, risks, and benefits of 2 or more medical treatments, services, and items described in subparagraph (B).

(B) MEDICAL TREATMENTS, SERVICES, AND ITEMS DESCRIBED.—The medical treatments, services, and items described in this subparagraph are health care interventions, prototypes for treatments, and delivery, procedures, medical devices, diagnostic tools, pharmaceuticals (including drugs and biologicals), integrative health treatments, and any other items being used in the treatment, management, and diagnosis of, or prevention of illness or injury in, individuals.

4(4) REAL CONFLICT OF INTEREST.—The term ‘real conflict of interest’ means any association, including a financial or personal association, that have the potential to bias or have the appearance of bias and individual’s decisions in matters related to the Institute or the conduct of activities under this section.

5(5) INTELLECTUAL PROPERTY.—The term ‘intellectual property’ means any invention or discovery that originates from study conducted under this section or from any other source.

6(6) PATIENT-CENTERED OUTCOMES RESEARCH INSTITUTE.—

(A) ESTABLISHMENT.—There is authorized to be established a nonprofit corporation, to be known as the ‘Patient-Centered Outcomes Research Institute’ (referred to in this section as the ‘Institute’) which is neither an agency nor establishment of the United States Government nor an arm of the Federal Government.

(B) FUNDING.—(1) NOTIFICATION.—The Secretary of Health and Human Services shall notify the Secretary of the Treasury of the amount necessary to carry out this program under this section for the period of fiscal years 2010 through 2012, except that in no case shall such amount exceed $160,000,000.

(2) TRANSFER OF FUNDS.—(A) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, the amounts specified as necessary to carry out this program under this section for the period of fiscal years 2010 through 2012, except that in no case shall such amount exceed $160,000,000.

(B) RESERVATION OF FUNDS FOR CONDUCT OF EVALUATION.—The Secretary may reserve not more than $5,000,000 of the amount transferred under subparagraph (A) for the conduct of the evaluation under section 3321(b)(1).
‘(b) Appropriate academic research, private sector research, or study-conducting entities.

(ii) Preference.—In entering into contracts and managing such contracts, the Institute shall grant preference to the Agency for Healthcare Research and Quality and the National Institutes of Health, but only if the research to be conducted under such contract is authorized by the governing statutes of such Agency or Institutes.

(2) CONDITIONS FOR CONTRACTS.—A contract under paragraph (h) that applies to the Institute with respect to the research managed or conducted under such contract:

(I) shall abide by the transparency and conflicts of interest requirements under paragraph (b) that apply to the Institute with respect to the research managed or conducted under such contract;

(II) shall comply with the methodological standards adopted under paragraph (9) with respect to such research; and

(III) shall consult with the expert advisory panels for clinical trials and rare disease pointed out under subsection (A) and (III), respectively, of paragraph (4)(A):

(iv) REQUIREMENTS FOR PUBLICATION OF FINDINGS.—Research shall be designed, as used with various subpopulations, such as racial and ethnic minorities, women, age, and groups of individuals with different comorbidities, genetic and molecular subtypes, or quality of life preferences and include members of such subpopulations as subjects in the research as feasible and appropriate, to take into account the potential for differences determined necessary by the Institute to carry out the research agenda adopted under paragraph (2).

(2) COVERAGE OF COPAYMENTS OR COINSURANCE.—If coverage for copayments or coinsurance, or allow for other appropriate measures, to the extent that such coverage or other measures are necessary to preserve the validity of a research project, such as in the case where the research project must be blinded.

(3) CONFIDENTIALITY OF RESEARCH.—Any research published under clause (i) or (IV) shall be within the bounds of and entirely consistent with the evidence and findings produced under the contract with the Institute under this subparagraph.

If the Institute determines that those requirements are not met, the Institute shall not be permitted by the agency, instrumentality, or entity which managed or conducted such research for a period determined appropriate by the Institute (but not less than 3 years).

(C) REVIEW AND UPDATE OF EVIDENCE.—The Institute shall review and update evidence on a periodic basis as appropriate.

(D) TAKING INTO ACCOUNT POTENTIAL DIFFERENCES.—Research shall be designed, as appropriate, to take into account the potential for differences in the effectiveness of health care treatments, services, and items as used with various subpopulations, such as racial and ethnic minorities, women, age, and groups of individuals with different comorbidities, genetic and molecular subtypes, or quality of life preferences and include members of such subpopulations as subjects in the research as feasible and appropriate.

(E) DIFFERENCES IN TREATMENT MODALITIES.—Research shall be designed, as appropriate, to take into account different characteristics of the patient population that may affect research outcomes, such as the phase of the treatment modality in the innovation cycle and the impact of the skill of the operator of the treatment modality.

(2) DATA COLLECTION.—

(A) IN GENERAL.—The Secretary shall, with appropriate safeguards for privacy, make available to the Institute such data collected by the Centers for Medicare & Medicaid Services under the programs under titles XVIII, XIX, and XXI, as well as provide access to the data network developed under section 937(f) of the Public Health Service Act, as the Institute and its contractors may require to carry out this section. The Institute shall also request and obtain data from Federal, State, or private entities, including data from clinical databases and registries.

(B) USE OF DATA.—The Institute shall only use the data provided under subparagraph (A) in accordance with laws and regulations governing the release and use of such data, including applicable confidentiality requirements.

(3) APPOINTING EXPERT ADVISORY PANELS.—

(A) APPOINTMENT.—The Institute may appoint permanent or ad hoc expert advisory panels as determined appropriate to assist in identifying research priorities and establishing the research project agenda under paragraph (1) and for other purposes.

(B) EXPERT ADVISORY PANELS FOR CLINICAL TRIALS.—The Institute shall appoint expert advisory panels in carrying out randomized clinical trials under the research project agenda under paragraph (2)(A)(1). Such expert advisory panels shall advise the Institute and the agency, instrumentality, or entity conducting the research on the research question involved and the research design or protocol, including important patient subgroups and other parameters of the research. Such panels shall be available as a resource for technical questions that may arise during the conduct of such research.

(4) EXPERT ADVISORY PANEL FOR RARE DISEASE.—In the case of a research study for rare disease, the Institute shall appoint an expert advisory panel for purposes of assisting in the design of the research study and determining the relative value and feasibility of conducting the research study.

(B) COMPOSITION.—An expert advisory panel appointed under subparagraph (A) shall include representatives of research clinicians, patients, and experts in scientific and health services research, health services delivery, and evidence-based medicine, who have expertise in the relevant topic, and as appropriate, experts in integrative health and primary prevention strategies. The Institute may include a technical expert of each manufacturer or each medical technology that is included under the relevant topic, project, or category for which the panel is established.

(C) SUPPORTING PATIENT AND CONSUMER REPRESENTATIVES.—The Institute shall provide support and resources to help patient and consumer representatives effectively participate on the Board and expert advisory panels appointed by the Institute under paragraph (4).

(6) ESTABLISHING METHODOLOGY COMMITTEE.—

(A) IN GENERAL.—The Institute shall establish a standing methodology committee to carry out the functions described in subparagraph (C).

(B) APPOINTMENT AND COMPOSITION.—The methodology committee established under subparagraph (A) shall be composed of not more than 15 members appointed by the Comptroller General of the United States. Members appointed to the methodology committee shall be experts in their scientific
field, such as health services research, clinical research, comparative clinical effectiveness research, biostatistics, genomics, and research methodologies. Stakeholders with such expertise shall be appointed to the methodology committee. In addition to the members appointed under the first sentence, the Directors of the National Institutes of Health for Healthcare Research and Quality (or their designees) shall each be included as members of the methodology committee.

(3) BORNEO.—Subject to subparagraph (D), the methodology committee shall work to develop and improve the science and methods of comparative clinical effectiveness research by promoting and evaluating the design of research. Any methodological standards developed and updated by the methodology committee shall be reviewed to assess scientific validity, generalizability, feasibility, and timeliness of research and for health outcomes measures, risk adjustment, and other relevant aspects of research and assessment with respect to the design of research. Any methodological standards developed and updated under this subsection to determine the scientific validity and include methods by which new information, data, or advances in technology are considered in the analysis of the scientific validity and include methods by which new information, data, or advances in technology are considered in the analysis of the scientific validity of research project or the matter that could affect or be affected by such participation.

(4) BORNEO.—In the case where the Institute enters into a contract or other agreement with another entity for the development of research under this section, the Institute may utilize the peer-review process of such entity if such process meets the requirements under subparagraphs (A) and (B).

(5) PROVIDING FOR A PEER-REVIEW PROCESS.—In the case where the Institute does not adopt or be affected by such participation.

(6) BORNEO.—In the case where the Institute does not adopt such processes in accordance with the preceding sentence, the processes shall be referred to the Board for more than 2 terms. Vacancies shall be staggered evenly over 2-year increments.

(7) PROVIDING FOR A PEER-REVIEW PROCESS FOR PRIMARY RESEARCH.—

(A) IN GENERAL.—The Institute shall ensure that any processes for peer review of primary research described in subparagraph (A)(ii) of paragraph (2) that is conducted under such paragraph. Under such process—

(B) THE INSTITUTE shall adopt the national standards identified under paragraph (1)(A) and methodology standards developed and updated by the methodology committee for further review.

(C) ANNUAL REPORT.—The Institute shall submit an annual report to Congress and the President, and shall make the annual report available to the public. Such report shall contain—

(A) a description of the activities conducted under this section, research priorities identified under paragraph (1)(A) and methodological standards developed and updated by the methodology committee under paragraph (6)(C)(i) that are adopted under paragraph (9) during the preceding year;

(B) the names of individuals contributing to any peer-review process during the preceding year or years shall be made public and included in annual reports in accordance with paragraph (10)(D);

(C) any administrative activities conducted by the Institute during the preceding year;

(7) without identifying them with a particular research project; and

(E) any other relevant information (including information on the membership of the Board for more than 2 terms. Vacancies shall be staggered evenly over 2-year increments. No individual shall be appointed to the Board for more than 2 terms. Vacancies shall be filled in the same manner as the original appointment was made. A member of the Board shall be entitled to

(4) BORNEO.—The Comptroller General of the United States shall designate a Chairperson and Vice Chairperson of the Board among the members of the Board. Such members shall serve as Chairperson or Vice Chairperson for a period of 3 years.
(B) ANNUAL REPORTS.—Not later than April 1 of each year, the Comptroller General of the United States shall submit to Congress a report containing the results of the review conducted under paragraph (A) with respect to the preceding year (or years, if applicable), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

(b) ENSURING TRANSPARENCY, CREDIBILITY, AND ACCOUNTABILITY.—The Institute shall establish procedures to ensure that the following requirements for ensuring transparency, credibility, and access are met:

(1) PUBLIC AVAILABILITY.—The Institute shall provide for the conduct of financial audits of the audits on an annual basis by a private entity with expertise in conducting financial audits.

(2) REVIEW AND ANNUAL REPORTS.—

(A) REVIEW.—The Comptroller General of the United States shall review the following:

(i) Not less frequently than every 5 years, the implementation established by the Institute, including the research priorities and the conduct of research projects, in order to determine whether information produced by such projects is objective and credible, is produced in a manner consistent with the requirements under this section, and is developed through a transparent process.

(ii) Not less frequently than every 5 years, the dissemination and training activities and data networks established under section 937 of the Public Health Service Act, including the research priorities and the conduct of research projects, in order to determine whether the activities and data are produced in a manner consistent with the requirements under this section, and is developed through a transparent process.

(3) PUBLIC AVAILABILITY.—The Institute shall make available to the public and disclose through the official public Internet website of the Institute the following:

(A) Information contained in research findings, including the identity of stakeholders, the research methods and processes and as the Institute determines appropriate.

(B) The process and methods for the conduct of research, including the identity of the entity and the investigators conducting such research, and any conflicts of interests of such parties, any direct or indirect links the entity has to industry, and research protocols, including any systematic reviews.

(4) DISCLOSE CONFLICTS OF INTEREST.—(A) In General.—A conflict of interest shall be disclosed in the following manner:

(i) By the Institute in appointing members to an expert advisory panel under subsection (d)(7), and as the case may be, to contribute to any peer-review process under subsection (d)(6), and for employment as executive staff of the Institute.

(ii) By the Comptroller General in appointing members of the methodology committee under subsection (d)(6);

(iii) By the Institute in the annual report under subsection (d)(6)(B) that, in the case of individuals contributing to any such peer review process, such description shall be in a manner such that those individuals cannot be identified with a particular research project.

(B) MANNER OF DISCLOSURE.—Conflicts of interest shall be disclosed as described in paragraph (A), and shall be publicly available on the Internet website of the Institute and the Government Accountability Office. The information disclosed under the preceding sentence shall include the type, nature, and magnitude of the interests of the individual involved, except to the extent that the information would otherwise be covered under this section.

(5) CONTRACT FOR AUDIT.—The Institute shall support forums to increase public awareness and obtain and incorporate public input and feedback through media (such as an Internet website) on research priorities, research protocols, research misconduct, findings, and activities, or processes the Institute determines appropriate.

(6) PUBLIC AVAILABILITY.—The Institute shall make available to the public and disclose through the official public Internet website of the Institute the following:

(A) Information contained in research findings, including the identity of stakeholders, the research methods and processes and as the Institute determines appropriate.

(B) The process and methods for the conduct of research, including the identity of the entity and the investigators conducting such research, and any conflicts of interests of such parties, any direct or indirect links the entity has to industry, and research protocols, including any systematic reviews.

(7) NOTICE OF PUBLIC COMMENT PERIODS.—The Institute shall provide for the conduct of financial audits of the audits on an annual basis by a private entity with expertise in conducting financial audits.

(8) PUBLIC AVAILABILITY.—The Institute shall make available to the public and disclose through the official public Internet website of the Institute the following:

(A) Information contained in research findings, including the identity of stakeholders, the research methods and processes and as the Institute determines appropriate.

(B) The process and methods for the conduct of research, including the identity of the entity and the investigators conducting such research, and any conflicts of interests of such parties, any direct or indirect links the entity has to industry, and research protocols, including any systematic reviews.

(C) Notice of public comment periods under paragraph (1), including deadlines for public comments.

(D) Subsequent comments received during each of the public comment periods.

(9) IN GENERAL.—The Office of Community and Knowledge Transfer shall create informational tools that organize and disseminate research findings for physicians, health care providers, researchers, patients, payers, and policy makers.

(10) REQUIREMENTS.—The Office shall provide for the dissemination of the Institute’s research findings and government-funded research relevant to comparative clinical effectiveness research. The Office shall create informational tools that organize and disseminate research findings for physicians, health care providers, patients, payers, and policy makers.

(11) IN GENERAL.—The Office of Community and Knowledge Transfer (referred to in this section as the ‘Office’) shall provide for the dissemination of the Institute’s research findings and government-funded research relevant to comparative clinical effectiveness research. The Office shall create informational tools that organize and disseminate research findings for physicians, health care providers, patients, payers, and policy makers.

(12) REQUIREMENTS.—The Office shall provide for the dissemination of the Institute’s research findings and government-funded research relevant to comparative clinical effectiveness research. The Office shall create informational tools that organize and disseminate research findings for physicians, health care providers, patients, payers, and policy makers.

(13) IN GENERAL.—The Office of Community and Knowledge Transfer (referred to in this section as the ‘Office’) shall provide for the dissemination of the Institute’s research findings and government-funded research relevant to comparative clinical effectiveness research. The Office shall create informational tools that organize and disseminate research findings for physicians, health care providers, patients, payers, and policy makers.

(14) REQUIREMENTS.—The Office shall provide for the dissemination of the Institute’s research findings and government-funded research relevant to comparative clinical effectiveness research. The Office shall create informational tools that organize and disseminate research findings for physicians, health care providers, patients, payers, and policy makers.
to promote the timely incorporation of research findings disseminated under subsection (a) into clinical practices and to promote the ease of use of such incorporation.

(2) The Office shall establish a process to receive feedback from physicians, health care providers, patients, and vendors to assess to what extent the dissemination of the findings is facilitated or impeded by clinical decision support tools, professional associations, and Federal and private health plans.

(3) The Office shall submit a report to the Secretary on the process established under paragraph (2) and the assistance provided under this section.

(4) RULE OF CONSTRUCTION.—Nothing in this section shall preclude the Institute from extending the Social Security Act.

(b) The Use of Evidence to Determine Coverage, Reimbursement, or Incentive Programs.—In determining coverage, reimbursement, or incentive programs under title XVIII based on a comparison of the difference in the effectiveness of alternative treatments in extending an individual’s life due to that individual’s age, disability, or terminal illness.

(1) The Secretary shall not use evidence or findings from comparative clinical effectiveness research conducted under section 1181 in determining coverage, reimbursement, or incentive programs under title XVIII based on a comparison of the difference in the effectiveness of alternative treatments in extending an individual’s life due to that individual’s age, disability, or terminal illness.

(2) Nothing in paragraph (1) shall be construed to—

(a) limit the application of differential co-payments under title XVIII based on factors such as cost or type of service; or

(b) prevent the Secretary from using evidence or findings from such comparative clinical effectiveness research to limit comparative clinical effectiveness research in determining financial incentives under the Secretary before the beginning of the fiscal year.

(c) FEEDBACK.—The Ombudsman of the Patient-Centered Outcomes Research Institute shall establish a process to receive feedback from physicians, health care providers, patients, and vendors to assess to what extent the dissemination of the findings is facilitated or impeded by clinical decision support tools, professional associations, and Federal and private health plans.

(d) IN GENERAL.—The Federal Government may enter into agreements with the Institute, and accept and retain funds, for the conduct and support of research described in this section, provided that the research to be conducted or supported under such agreements is authorized under the governing statutes of such agencies and such agreements are in writing.

(e) AUTHORITY TO CONTRACT WITH THE INSTITUTION.—Agencies and instrumentalities of the Federal Government may enter into agreements with the Institute, and accept and retain funds, for the conduct and support of research described in this section, provided that the research to be conducted or supported under such agreements is authorized under the governing statutes of such agencies and such agreements are in writing.

(f) BUILDING DATA FOR RESEARCH.—The Secretary shall provide for the coordination of relevant research programs to build data capacity for comparative clinical effectiveness research, including the development and use of clinical registries and health outcomes research data networks, in order to develop and maintain a comprehensive, interoperable data network to collect, link, and analyze data on outcomes and effectiveness from multiple sources, including electronic health records.

(g) AUTHORITY TO CONTRACT WITH THE INSTITUTION.—Agencies and instrumentalities of the Federal Government may enter into agreements with the Institute, and accept and retain funds, for the conduct and support of research described in this section, provided that the research to be conducted or supported under such agreements is authorized under the governing statutes of such agencies and such agreements are in writing.

(h) LIMITATIONS ON CERTAIN USES OF COMPARATIVE CLINICAL EFFECTIVENESS RESEARCH.—

SEC. 1182. (a) The Secretary may only use evidence and findings from research conducted under subsection (a) to make a determination regarding coverage under title XVIII if such use is through an iterative and transparent process which includes public comment and considers the effect on subpopulations.

(b) Nothing in this section shall be construed to—

(1) supercede or modify the coverage of items or services under title XVIII that are reasonable and necessary.

(2) authorize the Secretary to deny coverage of items or services under title XVIII solely on the basis of comparative clinical effectiveness research conducted under section 1182(a)(1).

(c) The Secretary shall not use evidence or findings from comparative clinical effectiveness research conducted under section 1182(a)(1) to determine comparative effectiveness research conducted under section 1182 in determining coverage, reimbursement, or incentive programs under title XVIII in a manner that treats extending the life of an elderly, disabled, or terminally ill individual that has a value less than the value of extending the life of an individual who is younger, non-disabled, or not terminally ill.

SEC. 1183. (a) In General.—The Secretary shall provide for the conduct of research, from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1851(b)(1) of the Social Security Act to the total expenditures during such fiscal year that are made under title XVIII from the respective trust fund, to the Patient-Centered Outcomes Research Trust Fund (referred to in this section as the ‘PCORTF’), consisting of such amounts as may be appropriated or credited to such Trust Fund as provided in this section.

(b) PATIENT-CENTERED OUTCOMES RESEARCH TRUST FUND; FINANCING FOR TRUST FUND.—

SEC. 1184. (a) Creation of Trust Fund.—There is established in the Treasury of the United States a trust fund to be known as the ‘Patient-Centered Outcomes Research Trust Fund’ (hereafter in this section referred to as the ‘PCORTF’), consisting of such amounts as may be appropriated or credited to such Trust Fund as provided in this section and section 9602(b).

(b) Transfers to Fund.—

(1) Appropriation.—There are hereby appropriated to the Trust Fund the following:

(A) For fiscal year 2010, $10,000,000.

(B) For fiscal year 2011, $50,000,000.

(C) For fiscal year 2012, $150,000,000.

(D) For fiscal year 2013—

(i) an amount equivalent to the net revenues received in the Treasury from the fees imposed under subchapter B of chapter 34 (relating to fees on health insurance and self-insured plans) for such fiscal year; and

(ii) $150,000,000.

(E) For each of fiscal years 2014, 2015, 2016, 2017, 2018, and 2019—

(i) an amount equivalent to the net revenues received in the Treasury from the fees imposed under subchapter B of chapter 34 (relating to fees on health insurance and self-insured plans) for such fiscal year; and

(ii) $150,000,000.

The amounts appropriated under subparagraphs (A), (B), (C), (D)(ii), and (E)(ii) shall be transferred from the general fund of the Treasury, from funds not otherwise appropriated.

(2) Trust Fund Transfers.—In addition to the amounts appropriated under paragraph (1), there shall be credited to the PCORTF the amounts transferred under section 1183 of the Social Security Act.

(3) Limitation on Transfers to PCORTF.—No amount may be appropriated or transferred to the PCORTF on and after the date of any expenditure from the PCORTF which is not an expenditure permitted under this section. The determination of whether an expenditure is a permitted expenditure shall be made without regard to—

(A) any provision of law which is not contained or referenced in this chapter or in a provision appropriate to the PCORTF the amounts transferred under section 1183 of the Social Security Act.

(B) whether such provision of law is a subsequently enacted provision or directly or indirectly seeks to waive the application of this subparagraph.

(C) Trustee.—The Secretary of the Treasury shall be a trustee of the PCORTF.

(4) Expenditures From Fund.—

(5) Amounts Available to the Patient-Centered Outcomes Research Institute. Subject to paragraph (2), amounts in the
PCORTF are available, without further appropriation, to the Patient-Centered Outcomes Research Institute established under section 1181(b) of the Social Security Act for carrying out the purposes of the Social Security Act (as in effect on the date of enactment of such Act).

(2) TRANSFER OF FUNDS.—

(2)(A) in general.—The trustee of the PCORTF shall provide for the transfer from the PCORTF of 20 percent of the amounts appropriated or credited to the PCORTF for each fiscal year beginning on or after January 1, 2010, through 2016, to the Secretary of Health and Human Services to carry out section 937 of the Public Health Service Act.

(2)(B) AVAILABILITY.—Amounts transferred under subparagraph (A) shall remain available until expended.

(2)(C) EXEMPT PROVISIONS.—Of the amounts transferred under subparagraph (A) with respect to a fiscal year, the Secretary of Health and Human Services shall distribute—

(i) 80 percent to the Office of Communication and Knowledge Transfer of the Agency for Healthcare Research and Quality (or any other office designated by the Secretary for Healthcare Research and Quality) to carry out the activities described in section 937 of the Public Health Service Act; and

(ii) 20 percent to the Secretary to carry out the activities described in section 937 of the Public Health Service Act.

(3) NET REVENUES.—For purposes of this section, the term ‘net revenues’ means the amount estimated by the Secretary of the Treasury based on the excess of—

(1) the fees received in the Treasury under subchapter B of chapter 34, over

(2) the decrease in the tax imposed by chapter 1 resulting from the fees imposed by such chapter.

(4) TERMINATION.—No amounts shall be available for expenditure from the PCORTF after September 30, 2019, and any amounts in such Trust Fund after such date shall be transferred to the general fund of the Treasury.

(5) CLERICAL AMENDMENT.—The table of sections for subchapter A of chapter 98 of such Code is amended by adding at the end the following new item:

‘Sec. 9511. Patient-centered outcomes research trust fund.’

(6) FINANCING OF FUND FROM FEES ON INSURED AND SELF-INSURED HEALTH PLANS.—

(A) GENERAL RULE.—Chapter 34 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

Subchapter B—Insured and Self-Insured Health Plans.

‘Sec. 4376. Self-Insured Health Plans.

‘(a) IMPOSITION OF FEE.—In the case of any applicable self-insured health plan for plan years ending after September 30, 2012, there is hereby imposed a fee equal to $1.25 per capita amount of National Health Expenditures, as most recently published by the Secretary before the beginning of the fiscal year.

‘(b) LIABILITY FOR FEE.—(1) in general.—The fee imposed by subsection (a) shall be paid by the plan sponsor.

‘(2) PLAN SPONSOR.—For purposes of purposes of paragraph (1) the term ‘plan sponsor’ means—

(A) the employer in the case of a plan established or maintained by such employer or employee organization,

(B) the employee organization in the case of a plan established or maintained by an employee organization,

(C) in the case of—

(i) a plan established or maintained by 2 or more employers or jointly by 1 or more employers and 1 or more employee organizations,

(ii) a multiple employer welfare arrangement, or

(iii) a voluntary employees’ beneficiary association described in section 501(c)(9), the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan,

(D) the cooperative or association described in subsection (c)(2)(F) in the case of a plan established or maintained by such a cooperative or association.

‘(c) APPLICABLE SELF-INSURED HEALTH PLAN.—For purposes of this section, the term ‘applicable self-insured health plan’ means any plan for providing accident or health coverage which, if provided by an insurance policy, would cause such policy to be a specified health insurance policy (as defined in section 9832(c)).

‘(d) TREATMENT OF PREPAID HEALTH COVERAGE ARRANGEMENTS.—

(1) IN GENERAL.—In the case of any arrangement described in subparagraph (B), such arrangement shall be treated as a specified health coverage arrangement, and a person referred to in such subparagraph shall be treated as the issuer.

‘(2) DESCRIPTION OF ARRANGEMENTS.—An arrangement is described in this subparagraph if under such arrangement fixed payments or premiums are received as consideration for any person’s agreement to provide or arrange for the provision of accident or health coverage to residents of the United States, regardless of how such coverage is provided or arranged to be provided.

‘(3) TRANSFER OF FUNDS.—In the case of any policy year ending in any fiscal year beginning after September 30, 2014, the dollar amount in effect under subsection (a) for such policy year shall be equal to the sum of such dollar amount for policy years ending in the previous fiscal year (determined after the application of paragraph (1), plus an amount equal to the product of—

(A) such dollar amount for policy years ending in the previous fiscal year, multiplied by

(B) the percentage increase in the projected per capita amount of National Health Expenditures, as most recently published by the Secretary before the beginning of the fiscal year.

‘(4) TERMINATION.—This section shall not apply to plan years ending after September 30, 2019.

‘Sec. 4376. Self-Insured Health Plans.

‘(a) IMPOSITION OF FEE.—In the case of any applicable self-insured health plan for plan years ending after September 30, 2012, there is hereby imposed a fee equal to $2 (in the case of plan years ending during fiscal year 2013) multiplied by the average number of lives covered under the plan.

‘(b) LIABILITY FOR FEE.—(1) in general.—The fee imposed by subsection (a) shall be paid by the plan sponsor.

‘(2) PLAN SPONSOR.—For purposes of purposes of paragraph (1) the term ‘plan sponsor’ means—

(A) the employer in the case of a plan established or maintained by such employer or employee organization,

(B) the employee organization in the case of a plan established or maintained by an employee organization,

(C) in the case of—

(i) a plan established or maintained by 2 or more employers or jointly by 1 or more employers and 1 or more employee organizations,

(ii) a multiple employer welfare arrangement, or

(iii) a voluntary employees’ beneficiary association described in section 501(c)(9), the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan,

(D) the cooperative or association described in subsection (c)(2)(F) in the case of a plan established or maintained by such a cooperative or association.

‘(c) APPLICABLE SELF-INSURED HEALTH PLAN.—For purposes of this section, the term ‘applicable self-insured health plan’ means any plan for providing accident or health coverage if—

(1) any portion of such coverage is provided other than through an insurance policy, and

(2) such plan is established or main-
“(D) any program established by Federal law for providing medical care (other than through insurance policies) to members of Indian tribes (as defined in section 4(d) of the Indian Health Care Improvement Act).

“(c) TREATMENT AS TAX.—For purposes of subtitle F, the fees imposed by this subchapter shall be treated as if they were taxes.

“(d) NO COVER OVER TO POSSESSIONS.—Notwithstanding any other provision of law, no amount collected under this subchapter shall be considered as cover over to possession of the United States.”.

(B) CLERICAL AMENDMENTS.—

(i) Chapter 34 of such Code is amended by striking the chapter heading and inserting the following:

“CHAPTER 34—TAXES ON CERTAIN INSURANCE POLICIES

“SUBCHAPTER A. POLICIES ISSUED BY FOREIGN INSURERS

“SUBCHAPTER B. INSURED AND SELF-INSURED HEALTH PLANS

“Subchapter A—Policies Issued By Foreign Insurers

“(i) The table of chapters for subtitle D of such Code is amended by striking the item relating to chapter 34 and inserting the following new item:

“CHAPTER 34—TAXES ON CERTAIN INSURANCE POLICIES

“(j) Tax-Exempt Status of the Patient-Centered Outcomes Research Institute.—Subsection 501(i) of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:

“(4) The Patient-Centered Outcomes Research Institute established under section 111(b) of the Social Security Act.

SEC. 6002. FEDERAL COORDINATING COUNCIL FOR COMPARATIVE EFFECTIVENESS RESEARCH.

Notwithstanding any other provision of law, the Federal Coordinating Council for Comparative Effectiveness Research established under section 801 of Division A of the American Recovery and Reinvestment Act of 2009 (42 U.S.C. 299b–8), including the requirement under subsection (e)(2) of such section, shall terminate on the date of enactment of this Act.

Subtitle E—Medicare, Medicaid, and CHIP

Program Integrity Provisions

SEC. 6001. PROVIDER SCREENING AND OTHER ENROLLMENT REQUIREMENTS UNDER MEDICARE, MEDICAID, AND CHIP.

(a) Medicare.—Section 1866(i) of the Social Security Act (42 U.S.C. 1395cc(i)) is amended—

(1) in paragraph (1)(A), by adding at the end the following:

“Such process shall include screening of proposed providers and suppliers in accordance with paragraph (2), a provisional period of enhanced oversight in accordance with paragraph (3), disclosure requirements in accordance with paragraph (4), the imposition of temporary enrollment moratoria in accordance with paragraph (5), and the establishment of compliance programs in accordance with paragraph (6);

(2) by redesignating paragraph (2) as paragraph (7); and

(3) by inserting after paragraph (1) the following:

“(2) PROVIDER SCREENING.—

“(A) PROCEDURES.—Not later than 180 days after the date of enactment of this paragraph, in consultation with the Inspector General of the Department of Health and Human Services, shall establish procedures under which screening is conducted in accordance with this paragraph, including procedures for medical or other items or services and suppliers under the program under this title, the Medicaid program under title XIX, and the CHIP program under title XXI.

“(B) LEVEL OF SCREENING.—The Secretary shall determine the level of screening conducted under this paragraph in accordance with the risk of fraud, waste, and abuse, as determined by the Secretary, with respect to the category of provider of medical or other items or services or supplier. Such screening—

“(1) shall include a licensure check, which may include such checks across States; and

“(2) may include any other procedure appropriate based on the risk of fraud, waste, and abuse described in the preceding sentence, including—

“(I) fingerprinting;

“(II) background check;

“(III) unscheduled and unannounced site visits, including preenrollment site visits;

“(IV) database checks (including such checks across States); and

“(V) such other screening as the Secretary determines appropriate.

“(C) APPLICATION FEES.—

“(1) INITIAL FEES.—Except as provided in clause (ii), the Secretary shall impose a fee on each individual provider of medical or other items or services or supplier (such as a physician, physician assistant, nurse practitioner, or clinical nurse specialist) with respect to which screening is conducted under this paragraph in an amount equal to—

“(I) for 2010, $300; and

“(II) for 2011 and each subsequent year, the amount determined under this clause for the preceding year, adjusted by the percentage change in the consumer price index for all urban consumers (all items; United States city average) for the 12-month period ending with June of the previous year.

“(2) PROVIDER SCREENING.—

“(A) IN GENERAL.—Notwithstanding any other provision of law, no amount collected under this subchapter shall be considered as cover over to possession of the United States.”.
past due obligations described in subparagraph (B)(ii) of an obligated provider of services or supplier.

"(B) DEFINITIONS.—In this paragraph:

"(i) the term ‘obligated provider of services or supplier’ means a provider of services or supplier that has the same taxpayer identification number as assigned to it under section 6109 of the Internal Revenue Code of 1986 as is assigned to the obligated provider of services or supplier under such section, regardless of whether the applicable services or supplier is assigned a different billing number or national provider identification number under the program.

"(ii) the term ‘high-risk provider’ means a provider of services or supplier that owes a past due obligation under the program under this title (as determined by the Secretary).

"(6) TEMPORARY MORATORIUM ON ENROLLMENT OF NEW PROVIDERS.—

"(A) IN GENERAL.—The Secretary may impose a temporary moratorium on the enrollment of new providers and suppliers, including categories of providers of services and suppliers, in the program under this title, under the Medicaid program under title XIX, or under a waiver of the plan, if the Secretary determines that such moratorium is necessary to prevent or combat fraud, waste, or abuse under either such program.

"(B) LIMITATION ON REVIEW.—There shall be no judicial review under section 1889, section 1902, or, otherwise, of a temporary moratorium imposed under subparagraph (A).

"(7) COMPLIANCE PROGRAMS.—

"(A) IN GENERAL.—On or after the date of enactment of this Act, the Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall establish core elements for a compliance program under subparagraph (B) with respect to that provider or supplier and industry or category.

"(B) ESTABLISHMENT OF CORE ELEMENTS.—The Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall establish core elements for a compliance program under subparagraph (B), with respect to that provider or supplier and industry or category.

"(C) TIMELINE FOR IMPLEMENTATION.—The Secretary shall determine the timeline for the establishment of the core elements under subparagraph (B) and the date of the implementation of subparagraph (A) for providers or suppliers within a particular industry or category. The Secretary shall, in determining such date of implementation, consider the extent to which the adoption of core elements by a provider of medical care or other items or services or supplier within a particular industry or category, or category, shall, as a condition of enrollment in the program under this title, title XIX, or title XXI, establish a compliance program that contains the core elements established under subparagraph (B) with respect to that provider or supplier and industry or category.

"(D) ENROLLMENT AND NPI OF ORDERING OR REFERRING PROVIDERS.—The State requires providers and suppliers under the State plan or under a waiver of the plan to enter into agreements with the individuals share and match data in the system of records of the respective agencies of such individuals. Such agreements shall include a minimum, claims and payment data from the following:

"(i) The programs under titles XVIII and XIX, including parts A, B, C, and D of title XVIII.

"(II) The program under title XXI.

"(III) Health-related programs administered by the Secretary of Veterans Affairs.

"(IV) Health-related programs administered by the Secretary of Defense.

"(V) The program of oil-age, survivors, and family health insurance benefits established under title II.

"(VI) The Indian Health Service and the Contract Health Service program.

"(7) ENROLLMENT AND NPI OF ORDERING OR REFERRING PROVIDERS.—The State requires—

"(A) all ordering or referring physicians or other professionals to be enrolled under the State plan or under a waiver of the plan as a participating provider; and

"(B) the national provider identifier of any ordering or referring physician or other professional to be specified on any claim for payment that is based on an order or referral of the physician or other professional.

"(8) OTHER STATE OVERSIGHT.—Nothing in this section shall preclude or limit the authority of a State to engage in provider and supplier screening or enhanced provider and supplier oversight activities beyond those required by the Secretary.

"(2) DISCLOSURE OF MEDICARE TERMINATED BILLING IDENTIFICATION NUMBER AND OTHER IDENTIFIERS TO STATES.—The Administrator of the Centers for Medicare & Medicaid Services shall establish a process for making available to the each State agency responsible for administering the Medicare program (or a waiver of such plan) under title XIX of the Social Security Act or a child health plan under title XXI the name, national identification number, and other identifying information for any provider of medical or other items or services or supplier under the Medicare program under the plan (or under a waiver of such plan) under title XXI that is terminated as of the date of enforcement of this subsection and, with respect to all such providers or suppliers who are terminated from the Medicare program on the date of enactment of this Act, within 90 days of such date.

"(3) CONFORMING AMENDMENT.—Section 1902(a)(23) of the Social Security Act (42 U.S.C. 1396a), is amended by inserting before the semicolon at the end the following: ‘or by a provider or supplier to which a moratorium under subsection (ii)(4) is applied during the period of such moratorium’.

"(d) CHIMP.—Section 2107(e)(1) of the Social Security Act (42 U.S.C. 1320d-11), as amended by section 2101(d), is amended—

"(1) by redesignating subparagraphs (D) through (M) as subparagraphs (E) through (S), respectively; and

"(2) by inserting after subparagraph (C), the following:

DAC. 602. ENHANCED MEDICARE AND MEDICAID PROGRAM INTEGRITY PROVISIONS.

"(a) GENERAL.—(1) INCLUSION OF CERTAIN DATA.—

"(A) INCLUSION OF CERTAIN DATA.—

"(B) DATA SHARING AND MATCHING.—Inclusion of the data described in clause (i) of such clause in the Integrated Data Repository as appropriate.
Human Services for the purpose of identifying potential fraud, waste, and abuse under the programs under titles XVIII and XIX.

(ii) INDIVIDUALS DESCRIBED.—The following individuals are described in this clause:


"(II) The Secretary of Veterans Affairs.

"(III) The Administrator of the Department of Defense.

"(IV) The Director of the Indian Health Service.

(iii) DEFINITION OF SYSTEM OF RECORDS.—For purposes of this paragraph, the term ‘system of records’ has the meaning given such term in section 552a(a)(5) of title 5, United States Code.

(iv) MAINTENANCE OF RECORDS.—For purposes of conducting law enforcement and oversight activities and to the extent consistent with applicable information, privacy, security, and disclosure laws, including the regulations promulgated under the Health Insurance Portability and Accountability Act of 1996 and section 552a of title 5, United States Code, and subject to any information systems security requirements under such laws or otherwise required by the Secretary, the Inspector General of the Department of Health and Human Services and the Attorney General shall have access to claims and payment data of the Department of Health and Human Services and its contractors related to titles XVIII, XIX, and XXI.

(b) OIG AUTHORITY TO OBTAIN INFORMATION.—

"(1) IN GENERAL.—Notwithstanding and in addition to any other provision of law, the Inspector General of the Department of Health and Human Services may, for purposes of conducting health oversight activities and the Attorney General shall have access to claims and payment data of the Department of Health and Human Services and its contractors related to titles XVIII, XIX, and X X I.

"(2) ACCESS TO DATA.—

"(A) By the Attorney General and the Secretary, the Inspector General of the Department of Health and Human Services may, for purposes of conducting health oversight activities, access claims and payment data of the Department of Health and Human Services and its contractors related to titles XVIII, XIX, and XXI.

(c) WITHHOLDING OF FEDERAL MATCHING PAYMENTS FOR STATES THAT FAIL TO REPORT ENROLLEE ENCOUNTER DATA IN THE MEDICAID STATISTICAL INFORMATION SYSTEM.—Section 1903(k)(1) of the Social Security Act (42 U.S.C. 1396k) is amended by adding at the end the following new paragraph:

"(3) The Secretary of Health and Human Services may, in carrying out health oversight activities and the Attorney General shall have access to claims and payment data of the Department of Health and Human Services and its contractors related to titles XVIII, XIX, and XXI.

(d) PERMISSIVE EXCLUSIONS AND CIVIL MONETARY PENALTIES.—

"(1) PERMISSIVE EXCLUSIONS.—Section 1128(a)(3) of the Social Security Act (42 U.S.C. 1320a-7(b)) is amended by adding at the end the following new paragraph:

"(2) CIVIL MONETARY PENALTIES.—

"(A) IN GENERAL.—Section 1128(a)(1) of the Social Security Act (42 U.S.C. 1320a-7(a)) is amended by striking "was excluded" and all that follows through the period at the end and inserting "was excluded"
from the Federal health care program (as defined in section 1122B(f)) under which the claim was made pursuant to Federal law;'’; (ii) in paragraph (6), by striking ‘‘or’’ at the end; (iii) by inserting after paragraph (7), the following new paragraphs: ‘‘(8) orders or prescribes a medical or other item or service during a period in which the person is participating under such a program; ‘‘(9) knowingly makes or causes to be made any false statement, omission, or misrepresentation of a material fact in any application, notice, report, or claim submitted as a provider of services or a supplier under a Federal health care program (as so defined), including Medicare Advantage organization (as defined in part C of title XVIII), prescription drug plan sponsors under part D of title XVIII, Medicaid managed care organizations under title XIX, and entities that apply to participate as providers of services or suppliers in such managed care organizations and such plans; ‘‘(10) knows of an overpayment (as defined in section 1122B(d)) and does not report and return the overpayment in accordance with such section;’’; (iv) in the first sentence— (I) by striking ‘‘or’’ after ‘‘prohibited relationship’’; and (II) by striking ‘‘act’’ and inserting ‘‘act; or’’ in cases under paragraph (9), $50,000 for each false statement or misrepresentation of a material fact;’’; and (v) in the second sentence, by striking ‘‘purpose’’ and inserting ‘‘purpose; or in cases under paragraph (9), $50,000 for each false statement or misrepresentation of a material fact’’; and (B) CLARIFICATION OF TREATMENT OF CERTAIN CHARITABLE AND OTHER INNOCUOUS PROVISIONS.—Section 1122A(i)(6) of the Social Security Act (42 U.S.C. 1320a–7a(i)(6)) is amended— (1) in subparagraph (C), by striking ‘‘or’’ at the end; (2) in subparagraph (D), as redesignated by section 4331(e) of the Balanced Budget Act of 1997 (Public Law 105–33), by striking the period at the end. (3) REQUIREMENTS FOR CERTAIN OTHER PROVIDERS OF SERVICES AND SUPPLIERS.—Section 1557 of such Act (42 U.S.C. 1557) is amended by adding at the end the following new subsection: ‘‘(m) CONSENT.—The Secretary may rely on any statement of consent, as determined by the Secretary on a continuing basis with a surety bond requirements under sections 1861(s)(5)(A)(ii) and 1861(s)(6)(E)(i).’’ (4) FRAUD.—The Secretary may take any action that the Secretary determines is commensurate with the volume of the billing of the provider of services or supplier. The Secretary may waive the requirement of a bond under the preceding sentence in the case of a provider of services or supplier that provides a comparable surety bond under State law. (2) PROVIDER OF SERVICES OR SUPPLIER DESCRIBED.—A provider of services or supplier described in this paragraph of services or supplier the Secretary determines appropriate based on the level of risk associated with the provider of services or supplier, and consistent with the surety bond requirements under sections 1861(s)(5)(A)(ii) and 1861(s)(6)(E)(i).’’ (3) SUSPENSION OF PAYMENTS PENDING INVESTIGATION OF CREDIBLE ALLEGATIONS OF FRAUD.— (1) MEDICARE.—Section 1862 of the Social Security Act (42 U.S.C. 1395y), as amended by subsection (g)(3), is amended by adding at the end the following new subsection— ‘‘(f) SUSPENSION OF PAYMENTS PENDING INVESTIGATION OF CREDIBLE ALLEGATIONS OF FRAUD.— ‘‘(1) IN GENERAL.—The Secretary may suspend payments to a provider of services or supplier under this title pending an investigation of a credible allegation of fraud against the provider of services or supplier, and consistent with the Secretary, there is good cause not to suspend such payments. ‘‘(2) CONSULTATION.—The Secretary shall consult with the Inspector General of the Department of Health and Human Services in determining whether there is a credible allegation of fraud against a provider of services or supplier. ‘‘(3) PROCLAMATION OF REGULATIONS.—The Secretary shall promulgate regulations to carry out this subsection and section 1902(a)(13).’’ (2) MEDICAID.—Section 1902(a)(2) of such Act (42 U.S.C. 1396n(1)(2)) is amended— (A) in subparagraph (A), by striking ‘‘or’’ at the end; and (B) by inserting after subparagraph (B), the following: ‘‘(C) by any individual or entity to whom the Secretary has failed to suspend payments under this plan during any period after the end of the calendar year in which such individual or entity became aware of information or circumstances which, if true, would constitute a credible demonstration of the likelihood of fraud against the provider of services or supplier;’’ (3) INCREASED FUNDING TO FIGHT FRAUD AND ABUSE.— (1) IN GENERAL.—Section 1871(k) of the Social Security Act (42 U.S.C. 1395f(k)) is amended by adding at the end the following new paragraph: ‘‘(7) ADDITIONAL FUNDING.—In addition to the funds otherwise appropriated to the Account from the Trust Fund under paragraphs (3) and (4) for purposes described in paragraphs (3)(C) and (4)(A), there are hereby appropriated an additional $10,000,000 to such Account from such Trust Fund for each of fiscal years 2011 through 2020. The funds appropriated under this paragraph shall be allocated in the same proportion as the total funds otherwise appropriated to the Account from such Trust Fund determined in each of the fiscal years 2011 through 2020. The funds appropriated under this paragraph shall be allocated to the Secretary to be used to fund additional inspections of providers of services and suppliers as described in paragraph (3)(C) and (4)(A) to ensure that appropriate steps are taken to address compliance with requirements of the Secretary under this subsection.’’
(2) INDEXING OF AMOUNTS APPROPRIATED.—
(A) DEPARTMENTS OF HEALTH AND HUMAN SERVICES AND JUSTICE.—Section 1817(k)(3)(A)(i) of the Social Security Act (42 U.S.C. 1395ddd(c)(3)(A)(i)) is amended—
(1) in subsection (i), by inserting “and” at the end; and
(2) in subsection (IV), by inserting “for each fiscal year after fiscal year 2008” and “after fiscal year 2008”; and
(3) by striking “;” and inserting a period; and
(4) by striking subsection (V).
(B) OFFICE OF THE INSPECTOR GENERAL OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.—Section 1817(k)(3)(B) of the Social Security Act (42 U.S.C. 1395ddd(c)(3)(B)) is amended—
(1) in clause (viii), by inserting “and” at the end; and
(2) in subsection (IX), by inserting “for each fiscal year after fiscal year 2008” and “after fiscal year 2008”; and
(3) by striking “;” and inserting a period; and
(4) by striking subsection (X).
(C) MEDICARE INTEGRITY PROGRAM.—Section 1817(k)(4) of the Social Security Act (42 U.S.C. 1395ddd(c)(4)) is amended—
(i) in paragraph (3), by striking “and” at the end; and
(ii) by inserting after paragraph (3) the following new paragraph:
“(4) EVALUATIONS.—The Secretary shall conduct evaluations of eligible entities under this program not less frequently than every 3 years.”

(D) MEDICARE INTEGRITY PROGRAM AND MEDICARE INTEGRITY PROGRAM AND THE NATIONAL PRACTITIONER DATA BANK.—
(A) REQUIREMENT TO PROVIDE PERFORMANCE STATISTICS.—Section 1893(c) of the Social Security Act (42 U.S.C. 1395ddd(c)) is amended—
(1) in paragraph (5), by striking “entities” for “entities or otherwise,” after “entities”; and
(2) MEDICINE INTEGRITY PROGRAM.—
(i) REQUIREMENT TO PROVIDE PERFORMANCE STATISTICS.—Section 1893(c)(2) of the Social Security Act (42 U.S.C. 1395ddd(c)(2)) is amended—
(1) by redesigning subparagraph (D) as subparagraph (E); and
(2) by inserting after subparagraph (C) the following new subparagraph:
“(D) The entity agrees to provide the Secretary and the Inspector General of the Department of Health and Human Services with such performance statistics (including the number and amount of overpayments recovered, the number of fraud referrals, and the return on investment of such activities by the entity) as the Secretary or the Inspector General may request.”

(B) EVALUATION AND ANNUAL REPORT.—Section 1936 of the Social Security Act (42 U.S.C. 1396r–2) is amended by striking paragraph (2), by striking “the authority” and substituting “the authority shall provide for the maximum appropriate coordination with part B of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 1111 et seq.) and section 1931;” and
(4) in subsection (g)—
(1) in paragraph (1)(A)—
(i) in clause (i), by striking “or State” each place it appears;
(II) by redesigning subparagraphs (II) and (III) as subparagraphs (III) and (IV), respectively; and
(III) by inserting after subparagraph (I) the following new subparagraph:
“(II) any dismissal or closure of the proceeding by reason of the provider, supplier, or practitioner surrendering their license or leaving the State or jurisdiction;” and
(ii) by striking clause (iv) and inserting the following:
“(iv) Exclusion from participation in a Federal health care program (as defined in section 1129(k)(3));”

(B) in paragraph (3)—
(i) by striking subparagraphs (D) and (E); and
(ii) by redesigning subparagraph (F) as subparagraph (D); and
(C) in subparagraph (D) (as so redesignated), by striking “or State”.

(E) INFORMATION REPORTED BY STATE LAW OR FRAUD ENFORCEMENT AGENCIES.—Section 212 of the Social Security Act (42 U.S.C. 1395ddd–2) is amended—
(1) in subsection (a)—
(A) in paragraph (1)—
(i) by striking “SYSTEM.” and all that follows through the semicolon and inserting “STATE SYSTEM.”
(II) any dismissal or closure of the proceeding by reason of the provider, supplier, or practitioner surrendering their license or leaving the State or jurisdiction;” and
(ii) by striking clause (iv) and inserting the following:
“(A) LICENSING OR CERTIFICATION ACTIONS.—
The State must have in effect a system of reviewing and appropriating with respect to formal proceedings (as defined by the Secretary in regulations) concluded against a health care practitioner or entity by a State licensing or certification agency.”;

(ii) by redesigning subparagraphs (A) through (D) as clauses (i) through (iv), respectively, and indenting appropriately; and
(iii) in subparagraph (A)(iii) (as so redesignated)—
(1) by striking “license of” and inserting “license or the right to apply for, or renew, a license by”;
(II) by inserting “nonrenewability,” after “voluntary surrender,”; and
(III) by adding at the end the following new subparagraph:
“(B) OTHER FINAL ADVERSE ACTIONS.—The State must have in effect a system of reviewing and appropriating with respect to formal proceedings (as defined by the Secretary in regulations) concluded against a health care practitioner or entity by a State licensing or certification agency or State law or fraud enforcement agency.”;

(B) in paragraph (2), by striking “the authority described in paragraph (1)” and inserting “the authority described in paragraph (1), and
(2) by striking paragraph (2) and inserting the following:
“(2) to State licensing or certification agencies and Federal agencies responsible for the licensing and certification of health care providers, suppliers, and licensed health care practitioners;”;

(3) by striking subsection (f) and inserting the following:
“(F) APPROPRIATE COORDINATION.—In implementing this section, the Secretary shall not take into account the maximum appropriate coordination with part B of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 1111 et seq.) and section 1931;” and
(4) by striking subsection (g) before the comma at the end;
(C) by striking paragraph (5) and inserting the following:

‘‘(5) to State law or fraud enforcement agencies;’’

(D) by redesigning paragraphs (7) and (8) as paragraphs (8) and (9), respectively; and

(E) by inserting after paragraph (6) the following new paragraph:

‘‘(7) To health plans (as defined in section 1128B(c));’’

(3) by redesigning subsection (d) as subsection (b), and by inserting after subsection (c) the following new subsection:

‘‘(d) DISCLOSURE AND CORRECTION OF INFORMATION.—

(1) DISCLOSURE.—With respect to information required to substantiate subsection (a)(1), the Secretary shall—

(A) provide for disclosure of the information, upon request, to the health care practitioner who, or the entity that, is the subject of the information reported; and

(B) establish procedures for the case where the health care practitioner or entity disputes the accuracy of the information reported.

(2) CORRECTIONS.—Each State licensing or certification agency and State law or fraud enforcement agency shall report corrections to the Secretary of the information already reported about any formal proceeding or final adverse action described in subsection (a), in such form and manner as the Secretary prescribes by regulation.

‘‘(e) FEES FOR DISCLOSURE.—The Secretary may establish or approve reasonable fees for the disclosure of information under this section. The amount of such a fee may not exceed the costs of processing the requests for disclosure and of providing such information. Such fees shall be available to the Secretary to cover such costs.

‘‘(f) PROTECTION FROM LIABILITY FOR REPORTING.—No person or entity, including any agent designated by the Secretary in subsection (b), shall be held liable in any civil action with respect to any reporting of information as required under this section, without knowledge of the falsity of the information contained in the report.

‘‘(g) REFERENCES.—For purposes of this section:

(1) STATE LICENSING OR CERTIFICATION AGENCY.—The term ‘State licensing or certification agency’ includes any authority of a State (or of a political subdivision thereof) responsible for the licensing of health care practitioners (or any peer review organization or private accreditation entity reviewing the services provided by health care practitioners).

(2) STATE LAW OR FRAUD ENFORCEMENT AGENCY.—The term ‘State law or fraud enforcement agency’ includes—

(A) a State law enforcement agency; and

(B) a State Medicaid fraud control unit (as defined in section 1933(q)).

‘‘(3) FINAL ADVERSE ACTION.—

(1) IN GENERAL.—The Secretary shall promulgate regulations to carry out the amendments made by subsections (a) and (b).

(2) FUNDING.—

(A) Availability of fees.—Fees collected pursuant to section 1123(d)(2) of the Social Security Act prior to the effective date specified in paragraph (6) for the disclosure of information in the Healthcare Integrity and Protection Data Bank shall be available to the Secretary, without fiscal year limitation, for payment of costs related to the operation of the National Practitioner Data Bank.

(B) Availability of additional funds.—In addition to the fees described in subparagraph (A), any funds available to the Secretary or to the Inspector General of the Department of Health and Human Services for a purpose related to combating health care fraud, waste, or error shall be available to the extent necessary for operating the Healthcare Integrity and Protection Data Bank during the period specified in paragraph (1) for payment of the costs of operating the National Practitioner Data Bank.

(3) SPECIAL PROVISION FOR ACCESS TO THE NATIONAL PRACTITIONER DATA BANK BY THE DEPARTMENT OF VETERANS AFFAIRS.

(A) IN GENERAL.—Notwithstanding any other provision of law, during the 1-year period that begins on the effective date specified in paragraph (6) for the disclosure of information described in subparagraph (B), the Secretary may specify exceptions to the 1 calendar year period specified in such paragraph.

(B) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this subsection (a) apply to services furnished before January 1, 2010, a bill or request for payment under section 1395f(a)(15) for services furnished after the date of service, and a case of services furnished before January 1, 2010, that is pending on the later of—

(A) the date that is 1 year after such date of enactment of this Act and ends on the later of—

(i) the date that is 1 year after such date of enactment of this Act; or

(ii) the effective date of the regulations promulgated under paragraph (2);

(2) EFFECTIVE DATE.—The amendments made by subsections (a), (b), and (c) shall take effect on the first day after the final day of the transition period.

SEC. 6404. MAXIMUM PERIOD FOR SUBMISSION OF MEDICARE CLAIMS REDUCED TO NOT MORE THAN 12 MONTHS.

(a) REDUCING MAXIMUM PERIOD FOR SUBMISSION OF MEDICARE CLAIMS—

(1) IN GENERAL.—Section 1842(b)(3) of such Act (42 U.S.C. 1395b(a)(3)) is amended—

(A) in paragraph (1), by striking ‘‘period of 3 calendar years’’ and inserting ‘‘period ending 1 calendar year after the date of service’’; and

(B) by adding at the end of the following new sentence: ‘‘In applying paragraph (1), the Secretary may specify exceptions to the 1 calendar year period specified in such paragraph.’’

(2) REGULATIONS.—The Secretary shall promulgate regulations to carry out the amendments made by this subsection.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this subsection are effective before the beginning of the calendar year specified in paragraph (2) for purposes of section 1842(b)(3) of the Social Security Act (42 U.S.C. 1395b(a)(3)).

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to claims filed during the period beginning immediately before the effective date of this section, and ending immediately before the period beginning on such date and ending 12 months thereafter.
SEC. 6007. FACE TO FACE ENCOUNTER WITH PATIENT REQUIRED BEFORE PHYSICIANS MAY CERTIFY ELIGIBILITY FOR SERVICES OR DURABLE MEDICAL EQUIPMENT UNDER MEDICARE.

(a) CONDITION OF PAYMENT FOR MEDICARE HEALTH SERVICES.—

(1) PART A.—Section 1814(a)(2) of such Act (42 U.S.C. 1395a(a)(2)) is amended in the matter preceding subparagraph (A) by inserting “in the case of services described in subparagraph (C) of section 1866(j) of such Act (42 U.S.C. 1395cc(j)) or an eligible professional under section 1848(k)(3)(B),” before “or, in the case of services

(2) PART B.—Section 1835(a)(2) of such Act (42 U.S.C. 1395w-3(c)(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 1848(k)(3)(B),” after “a physician

(b) CONDITIONS OF PAYMENT.—Section 1834(m) of such Act (42 U.S.C. 1395w-3(c)(1)) is amended by—

(1) in paragraph (6), by striking “or” at the end; and

(2) by inserting after paragraph (7) the following new paragraphs:

“(8) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim for payment for items and services furnished under a Federal health care program, for the purpose of audits, investigations, or other statutory functions of the Inspector General of the Department of Health and Human Services;” and

“(9) fails to grant timely access, upon reasonable request (as defined by the Secretary in regulations), to the Inspector General of the Department of Health and Human Services, for the purpose of audits, investigations, or other statutory functions of the Inspector General of the Department of Health and Human Services;” and

(3) in the first sentence:

(A) by striking “or in cases under paragraph (7)” and inserting “in cases under paragraph (7)”;

(B) by striking “act” and inserting “acts, in cases under paragraph (8), $50,000 for each false record or statement, or in cases under paragraph (9), $15,000 for each day of the failure described in such paragraph”.

(b) MEDICARE ADVANTAGE AND PART D PLANS.—

(1) ENSURING TIMELY INSPECTIONS RELATING TO CONTRACTS WITH MA ORGANIZATIONS.—Section 1857(d)(2) of such Act (42 U.S.C. 1395w–27(d)(2)) is amended—

(A) in subparagraph (A), by inserting “timely” before “inspect” and

(B) in subparagraph (B), by inserting “timely” before “audit and inspect”.

(2) MARKETING VIOLATIONS.—Section 1857(c)(1) of the Social Security Act (42 U.S.C. 1395w–27(c)(1)) is amended—

(A) in subparagraph (A), by striking “or” at the end;

(B) by inserting after subparagraph (G) the following new subparagraphs:

“(H) employs or contracts with any individual or entity who engages in the conduct described in subparagraphs (A) through (J) of this paragraph;”;

(C) by adding at the end the following new sentence: “The Secretary may provide, in addition to any other remedies authorized by law, for any of the remedies described in paragraph (B), to the extent that the Secretary determines that any employee or agent of such organization, or any provider or supplier who contracts with such organization, has engaged in marketing restrictions described in subsections (b) and (j) of section 1851 or applicable implementing regulations or guidance; or

“(I) employs or contracts with any individual or entity who engages in the conduct described in subparagraphs (A) through (K) of this paragraph;”;

(3) PROVISION OF FALSE INFORMATION.—Section 1857(g)(2)(A) of the Social Security Act (42 U.S.C. 1395w–27(g)(2)(A)) is amended by—

(1) in paragraph (6), by striking “or” at the end; and

(2) by inserting after paragraph (7) the following new paragraphs:

“(8) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim for payment for items and services furnished under a Federal health care program, for the purpose of audits, investigations, or other statutory functions of the Inspector General of the Department of Health and Human Services;” and

“(9) fails to grant timely access, upon reasonable request (as defined by the Secretary in regulations), to the Inspector General of the Department of Health and Human Services, for the purpose of audits, investigations, or other statutory functions of the Inspector General of the Department of Health and Human Services;” and

(3) in the first sentence:

(A) by striking “or in cases under paragraph (7)” and inserting “in cases under paragraph (7)”;

(B) by striking “act” and inserting “acts, in cases under paragraph (8), $50,000 for each false record or statement, or in cases under paragraph (9), $15,000 for each day of the failure described in such paragraph”.

(c) OBSTRUCTION OF PROGRAM AUDITS.—Section 1128(b)(2) of the Social Security Act (42 U.S.C. 1320a–7k(b)(2)) is amended—

(1) in the heading, by inserting “OR AUDIT” after “INVESTIGATION”;

and
SEC. 6410. MEDICARE SELF-REFERRAL DISCLOSURE PROTOCOL.

(a) DEVELOPMENT OF SELF-REFERRAL DISCLOSURE PROTOCOL.—

(1) IN GENERAL.—The Secretary of Health and Human Services, in cooperation with the Inspector General of the Department of Health and Human Services, shall establish, not later than 6 months after the date of enactment of this Act, a protocol to enable health care providers of services and suppliers to disclose an actual or potential violation of section 1877 of the Social Security Act (42 U.S.C. 1395nn) pursuant to a self-referral disclosure protocol (in this section referred to as an “SRDP”). The SRDP shall include direction to health care providers of services and suppliers—

(A) a specific person, official, or office to whom such disclosures shall be made; and

(B) instruction on the implementation of the SRDP.

(b) REQUIREMENT TO EITHER COMPETITIVELY BID AREAS OR USE COMPETITIVE BID PRICES BY 2016.—Section 1834(a)(1)(F) of the Social Security Act (42 U.S.C. 1395a(1)(F)) as amended by section 6411 of this Act shall apply to acts committed on or after January 1, 2016.

(c) REPORT.—Not later than 18 months after the date on which the SRDP protocol is established under subsection (a)(1), the Secretary shall submit to Congress a report on the implementation of this section. Such report shall include—

(1) the number of health care providers of services and suppliers making disclosures pursuant to the SRDP;

(2) the amounts collected pursuant to the SRDP;

(3) the types of violations reported under the SRDP;

(4) such other information as may be necessary to evaluate the impact of this section.
the Administrator of the Centers for Medicare & Medicaid Services, shall submit an annual report to Congress concerning the effectiveness of the Recovery Audit Contractor program. The Administrator and Medicaid and Medicare shall include such reports recommendations for expanding or improving the program.

Subtitle F—Additional Medicaid Program Integrity Provisions

SEC. 6501. TERMINATION OF PROVIDER PARTICIPATION UNDER MEDICAID IF TERMINATED UNDER MEDICARE OR OTHER STATE PLAN.

Section 1902(a)(39) of the Social Security Act (42 U.S.C. 1396a(a)) is amended by inserting after paragraph (28)(B)(ii) the following:

“(29) the Secretary shall do the following:

(a) I N GENERAL.—Section 1902(a)(39) of the Social Security Act (42 U.S.C. 1396a(a)) is amended by inserting after paragraph (28)(B)(ii) the following:

(A) in subparagraph (C)—

(i) by adding at the end the following:

(ii) by adding at the end the following:

(B) in subparagraph (D)—

(i) by inserting before paragraph (28)(B)(ii) the following:

(ii) by adding at the end the following:

(C) in subparagraph (E)—

(i) by adding at the end the following:

(ii) by adding at the end the following:

(D) in subparagraph (F)—

(i) by adding at the end the following:

(ii) by adding at the end the following:

(E) in subparagraph (G)—

(i) by adding at the end the following:

(ii) by adding at the end the following:

(F) in subparagraph (H)—

(i) by adding at the end the following:

(ii) by adding at the end the following:

(G) in subparagraph (I)—

(i) by adding at the end the following:

(ii) by adding at the end the following:

(H) in subparagraph (J)—

(i) by adding at the end the following:

(ii) by adding at the end the following:

(I) in subparagraph (K)—

(i) by adding at the end the following:

(ii) by adding at the end the following:

(J) in subparagraph (L)—

(i) by adding at the end the following:

(ii) by adding at the end the following:

(K) in subparagraph (M)—

(i) by adding at the end the following:

(ii) by adding at the end the following:

(L) in subparagraph (N)—

(i) by adding at the end the following:

(ii) by adding at the end the following:

(M) in subparagraph (O)—

(i) by adding at the end the following:

(ii) by adding at the end the following:

(N) in subparagraph (P)—

(i) by adding at the end the following:

(ii) by adding at the end the following:

(O) in subparagraph (Q)—

(i) by adding at the end the following:

(ii) by adding at the end the following:

(P) in subparagraph (R)—

(i) by adding at the end the following:

(ii) by adding at the end the following:

(Q) in subparagraph (S)—

(i) by adding at the end the following:

(ii) by adding at the end the following:

(R) in subparagraph (T)—

(i) by adding at the end the following:

(ii) by adding at the end the following:

(S) in subparagraph (U)—

(i) by adding at the end the following:

(ii) by adding at the end the following:

(T) in subparagraph (V)—

(i) by adding at the end the following:

(ii) by adding at the end the following:

(U) in subparagraph (W)—

(i) by adding at the end the following:

(ii) by adding at the end the following:

(V) in subparagraph (X)—

(i) by adding at the end the following:

(ii) by adding at the end the following:

(W) in subparagraph (Y)—

(i) by adding at the end the following:

(ii) by adding at the end the following:

(X) in subparagraph (Z)—

(i) by adding at the end the following:

(ii) by adding at the end the following:

(Y) in paragraph (1)—

(i) by adding at the end the following:

(ii) by adding at the end the following:

(Z) in paragraph (2)—

(i) by adding at the end the following:

(ii) by adding at the end the following:

(aa) in paragraph (3)—

(i) by adding at the end the following:

(ii) by adding at the end the following:

(bb) in paragraph (4)—

(i) by adding at the end the following:

(ii) by adding at the end the following:

(cc) in paragraph (5)—

(i) by adding at the end the following:

(ii) by adding at the end the following:

(dd) in paragraph (6)—

(i) by adding at the end the following:

(ii) by adding at the end the following:

(ee) in paragraph (7)—

(i) by adding at the end the following:

(ii) by adding at the end the following:

(ff) in paragraph (8)—

(i) by adding at the end the following:

(ii) by adding at the end the following:

(gg) in paragraph (9)—

(i) by adding at the end the following:

(ii) by adding at the end the following:

(hh) in paragraph (10)—

(i) by adding at the end the following:

(ii) by adding at the end the following:

(ii) by adding at the end the following:

(jj) in paragraph (11)—

(i) by adding at the end the following:

(ii) by adding at the end the following:

(kk) in paragraph (12)—

(i) by adding at the end the following:

(ii) by adding at the end the following:

(ll) in paragraph (13)—

(i) by adding at the end the following:

(ii) by adding at the end the following:

(mm) in paragraph (14)—

(i) by adding at the end the following:

(ii) by adding at the end the following:

(nn) in paragraph (15)—

(i) by adding at the end the following:

(ii) by adding at the end the following:

(oo) in paragraph (16)—

(i) by adding at the end the following:

(ii) by adding at the end the following:

(pp) in paragraph (17)—

(i) by adding at the end the following:

(ii) by adding at the end the following:

(qq) in paragraph (18)—

(i) by adding at the end the following:

(ii) by adding at the end the following:

(rr) in paragraph (19)—

(i) by adding at the end the following:

(ii) by adding at the end the following:

(ss) in paragraph (20)—

(i) by adding at the end the following:

(ii) by adding at the end the following:

(tt) in paragraph (21)—

(i) by adding at the end the following:

(ii) by adding at the end the following:

(uu) in paragraph (22)—

(i) by adding at the end the following:

(ii) by adding at the end the following:

(vv) in paragraph (23)—

(i) by adding at the end the following:

(ii) by adding at the end the following:

(xx) in paragraph (24)—

(i) by adding at the end the following:

(ii) by adding at the end the following:

(yy) in paragraph (25)—

(i) by adding at the end the following:

(ii) by adding at the end the following:

(zz) in paragraph (26)—

(i) by adding at the end the following:

(ii) by adding at the end the following:

(1) in paragraph (1)—

(i) by adding at the end the following:

(ii) by adding at the end the following:

(b) RECTIFICATIVE ACTION.—The Secretary shall promulgate regulations that require states to correct any erroneous data elements from the national correct coding initiative administered by the Secretary with respect to such erroneous data elements from such national correct coding initiative, and to control improper coding leading to inappropriately paid claims and/or overpayments, of an ongoing or recurring nature, with new Medicaid Management Information System (MMIS) edits, audits, or other appropriate methodologies of that Initiative (or any other methodologies of that Initiative administered by the Secretary) under this title and no national correct coding methodologies have been established under such Initiative with respect to title XVIII.

(c) REPORT TO CONGRESS.—(1) the methods for such audits and/or overpayments, of an ongoing or recurring nature, with new Medicaid Management Information System (MMIS) edits, audits, or other appropriate methodologies (other than those of the national correct coding methodologies) that should be incorporated into claims filed under this title, (ii) the methods for such audits and/or overpayments, of an ongoing or recurring nature, with new Medicaid Management Information System (MMIS) edits, audits, or other appropriate methodologies of the national correct coding methodologies that should be incorporated into claims filed under this title, and (iii) the methods for such audits and/or overpayments, of an ongoing or recurring nature, with new Medicaid Management Information System (MMIS) edits, audits, or other appropriate methodologies of the national correct coding methodologies that should be incorporated into claims filed under this title.

(2) The methods under this subtitle are to be consistent with the methods under the national health insurance program, and no national correct coding methodologies have been established under such Initiative with respect to title XVIII.

SEC. 6601. DEFINITION OF FALSE STATEMENTS AND REPRESENTATIONS.

(a) PROHIBITION.—Part 5 of subpart B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131 et seq.), is amended by adding at the end the following:

(1) in paragraph (1)—

(i) by adding at the end the following:

(ii) by adding at the end the following:

(iii) by adding at the end the following:

(2) the benefits provided by such plan or arrangement;

(3) the regulatory status of such plan or arrangement under any Federal or
State law governing collective bargaining, labor management relations, or intern union affairs; or

(4) the regulatory status of such plan or other arrangement that does not fall within the meaning of the term ‘multiple employer welfare arrangement’ under section 3(40)(A).”.

(b) CONFORMING AMENDMENT.—Section 520 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131) is amended—

(1) by inserting “(a)” before “Any person”; and

(2) by adding at the end the following:

“(b) Any person that violates section 519 shall upon conviction be imprisoned not more than 2 years or fined under title 18, United States Code, or both.”.

(c) CONFORMING AMENDMENT.—The table of sections for part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding at the end the following:

“Sec. 519. Prohibition on false statement and representations.”

SEC. 6602. CLARIFYING DEFINITION.
Section 24(a)(2) of title 18, United States Code, is amended by inserting “or section 411, 511 or 511 of the Employee Retirement Income Security Act of 1974,” after “1954 of this title”.

SEC. 6603. DEVELOPMENT OF MODEL UNIFORM REPORT FORM.
Part C of title XXVII of the Public Health Service Act (42 U.S.C. 300gg-91 et seq.) is amended by adding at the end the following:

“SEC. 2794. UNIFORM FRAUD AND ABUSE REFERRAL FORMAT.
The Secretary shall request the National Association of Insurance Commissioners to develop a model uniform report form for private health insurance issuer seeking to refer suspected fraud and abuse to State insurance departments or other responsible State agencies for investigation. The Secretary shall request that the National Association of Insurance Commissioners develop recommendations for uniform reporting standards for such referrals.”

SEC. 6604. APPLICABILITY OF STATE LAW TO COMBAT FRAUD AND ABUSE.
(a) In GENERAL.—Part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131 et seq.), as amended by section 6601, is further amended by adding at the end the following:

“SEC. 520. APPLICABILITY OF STATE LAW TO COMBAT FRAUD AND ABUSE.
‘‘The Secretary, for the purpose of identifying, preventing, or prosecuting fraud and abuse, adopt regulatory standards establishing, or issue an order relating to a specific person establishing, that a person engaged in the business of providing insurance through a multiple employer welfare arrangement described in section 3(40) is subject to the laws of the States in which such person operates which regulate insurance in such State, notwithstanding section 514(b)(6) of this Act or the Liability Risk Retention Act of 1969, unless the Secretary determines that the State is otherwise preempted under any of such provisions. This section shall not apply to any plan or arrangement that does not fall within the meaning of the term ‘multiple employer welfare arrangement’ under section 3(40)(A).’’

(b) CONFORMING AMENDMENT.—The table of sections for part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, as amended by section 6601, is further amended by adding at the end the following:

“Sec. 520. Applicability of State law to combat fraud and abuse.”

SEC. 6605. ENABLING THE DEPARTMENT OF LABOR TO ISSUE ADMINISTRATIVE SUMMARY SEIZURE AND DESIST ORDER.

(1) by striking “Secretary may” and inserting “Secretary shall” and

(2) by inserting “may” after “in a State and may, by regulation, require”.

(b) CONFORMING AMENDMENT.—Section 521 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131 et seq.) is amended—

(1) in the section heading, by inserting “and desist arrangements and summary seizure orders against plans that are in financially hazardous condition.”;

(2) by striking “Secretary shall request the National Association of Insurance Commissioners develop recommendations for uniform reporting standards for such referrals.” and inserting “Secretary may issue regulations for the purpose of enforcing the provisions of this title.”;

(3) by inserting “The Secretary shall request the National Association of Insurance Commissioners to develop a model uniform report form for private health insurance issuer seeking to refer suspected fraud and abuse to State insurance departments or other responsible State agencies for investigation. The Secretary shall request that the National Association of Insurance Commissioners develop recommendations for uniform reporting standards for such referrals.” after “in a State and may, by regulation, require”;

(4) by inserting “Following:

“SEC. 521. ADMINISTRATIVE SUMMARY SEIZURE AND DESIST ORDERS AND SUMMARY SEIZURE ORDERS AGAINST MULTIPLE EMPLOYER WELFARE ARRANGEMENTS THAT ARE IN FINANCIALLY HAZARDS CONDITION.
(a) In GENERAL.—The Secretary may issue a cease and desist (ex parte) order under this title if it appears to the Secretary that the alleged conduct of a multiple employer welfare arrangement described in section 3(40), other than a plan or arrangement described in subsection (g), is fraudulent, or creates an immediate danger to the public safety or welfare, or is causing or can reasonably be expected to cause significant, imminent, and irparable public injury.

(b) HEARING.—A person who is adversely affected by the issuance of a cease and desist order under section (b) may request a hearing by the Secretary regarding such order. The Secretary may require that a proceeding under the section, including all related information and evidence, be conducted in a confidential manner.

(c) BURDEN OF PROOF.—The burden of proof in any hearing conducted under section (b) shall be on the party requesting the hearing to show cause why the cease and desist order should be set aside.

(d) DETERMINATION.—Based upon the evidence presented at a hearing under section (b), the cease and desist order may be modified, or set aside by the Secretary in whole or in part.

(e) SEIZURE.—The Secretary may issue a summary seizure order under this title if it appears to the Secretary that the alleged conduct of a multiple employer welfare arrangement is in a financially hazardous condition.

(f) REGULATIONS.—The Secretary may promulgate such regulations or other guidance as may be necessary or appropriate to carry out this section.

(g) EXCEPTION.—This section shall not apply to any plan or arrangement that does not fall within the meaning of the term ‘multiple employer welfare arrangement’ under section 3(40)(A).’’

SEC. 6606. NEW PLAN REGISTRATION WITH DEPARTMENT OF LABOR.
Section 10(i)(g) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001(i)) is amended—

(1) by striking “Secretary may” and inserting “Secretary shall”; and

(2) by inserting “may” after “in a State and may, by regulation, require”.

SEC. 6607. PERMITTING EVIDENTIARY PRIVILEGE AND CONFIDENTIAL COMMUNICATIONS.
Section 521 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1134) is amended by adding at the end the following:

“(d) The Secretary may promulgate a regulation that provides an evidentiary privilege for, and provides for the confidentiality of communications between or among, any of the following entities or their agents, consultants, or employees:

(1) A State insurance department.

(2) A State attorney general.

(3) The National Association of Insurance Commissioners.

(4) The Department of Labor.

(5) The Department of the Treasury.

(6) The Department of Health and Human Services.

(6) Any other Federal or State authority that the Secretary determines is appropriate for the purposes of enforcing the provisions of this title.

(6) The privilege established under subsection (d) shall apply to communications related to any investigation, audit, examination, or inquiry conducted or coordinated by any of the agencies. A communication that is privileged under subsection (d) shall not waive any privilege otherwise available to the communicating agency or to any person who provided the information that is communicated.”

Subtitle H—Elder Justice Act
SEC. 6701. SHORT TITLE OF SUBTITLE.
This subtitle may be cited as the “Elder Justice Act of 2009”.

SEC. 6702. DEFINITIONS.
Except as otherwise specifically provided, any term that is defined in section 1021(g) of the Social Security Act (as added by section 6603(a)) and is used in this subtitle has the meaning given such term by such section.

SEC. 6703. ELDER JUSTICE.
(a) ELDER JUSTICE.
(1) IN GENERAL.—Title XX of the Social Security Act (42 U.S.C. 1397 et seq.) is amended—

(A) in the heading, by inserting “AND ELDER JUSTICE” after “SOCIAL SERVICES”;

(B) by inserting before section 2001 the following:

“Subtitle A—Block Grants to States for Social Services;”.

and

(C) by adding at the end the following:

“Subtitle B—Elder Justice
SEC. 2011. DEFINITIONS.
“In this subtitle:

(1) ABUSE.—The term ‘abuse’ means the knowing inflicting of physical or psychological harm or the knowing deprivation of goods or services that are necessary to meet essential needs or to avoid physical or psychological harm.

(2) ADULT PROTECTIVE SERVICES.—The term "adult protective services" means services provided to adults as the Secretary may specify and includes services such as—

(A) receiving reports of adult abuse, neglect, or exploitation;

(B) investigating the reports described in subparagraph (A);

(C) case planning, monitoring, evaluation, and other case work and services; and

(D) providing, arranging for, or facilitating the provision of medical, social service, economic, legal, housing, law enforcement, or other protective, emergency, or support services.

(3) CAREGIVER.—The term ‘caregiver’ means an individual who has the responsibility of the care of an elder, either voluntarily, by contract, by receipt of payment for care, or as a result of the operation of law,
and means a family member or other individual who provides (on behalf of such individual or of a public or private agency, organization, or institution) compensated or uncompensated care to an elder who needs supportive services in any setting.

"(4) DIRECT CARE.—The term 'direct care' means care by an employee or contractor who provides supportive or long-term care services to a recipient.

"(5) ELDER.—The term 'elder' means an individual age 60 or older.

"(6) ELDER JUSTICE.—The term 'elder justice' means—

"(A) from a societal perspective, efforts to prevent, detect, treat, intervene in, and prosecute elder abuse, neglect, and exploitation; and

"(B) from an individual perspective, the recognition of an elder's rights, including the right to be free of abuse, neglect, and exploitation.

"(7) ELIGIBLE ENTITY.—The term 'eligible entity' means a State or local government agency, the Indian Tribal Organization, or any other public or private entity that is engaged in and has expertise in issues relating to elder justice or in a field necessary to provide the goods or services that are necessary to maintain the health or safety of an elder; or

"(B) self-neglect.

"(17) NURSING FACILITY.—

"(A) IN GENERAL.—The term 'nursing facility' has the meaning given such term under section 1919(a).

"(B) INCLUSION OF SKILLED NURSING FACILITY.—The term 'nursing facility' includes a skilled nursing facility (as defined in section 1919(a)).

"(18) SELF-NEGLECT.—The term 'self-neglect' means an adult's inability, due to physical or mental impairment or diminished capacity, to perform essential self-care tasks including—

"(A) obtaining essential food, clothing, shelter, and medical care;

"(B) obtaining goods and services necessary to maintain physical health, mental health, or general safety; or

"(C) managing one's own financial affairs.

"(19) SERIOUS BODILY INJURY.—

"(A) IN GENERAL.—The term 'serious bodily injury' means an injury—

"(i) involving extreme physical pain;

"(ii) involving substantial risk of death; or

"(iii) involving protracted loss or impairment of the function of a bodily member, organ, or mental faculty; or

"(iv) requiring medical intervention such as surgery, hospitalization, or physical rehabilitation.

"(B) CRIMINAL SEXUAL ABUSE.—Serious bodily injury shall be presumed to have occurred if the conduct causing the injury is conduct described in section 2241 (relating to aggravated sexual abuse) or 2251A (relating to sexual abuse) of title 18, United States Code, or any similar offense under State law.

"(20) SOCIAL.—The term 'social', when used with respect to a service, includes adult protective services.

"(21) STATE LEGAL ASSISTANCE DEVELOPER.—

"(A) The Secretary (or the Secretary's designee).

"(B) The Attorney General (or the Attorney General's designee).

"(C) If the head of each Federal department or agency or other governmental entity identified by the Chair referred to in subsection (d) as having responsibilities, or administering programs, relating to elder abuse, neglect, and exploitation.

"(22) STATE LONG-TERM CARE OMBUDSMAN.—

"(A) In general.—The term 'state long-term care ombudsman' means an individual age 60 or older.

"(B) RULE OF CONSTRUCTION.—Nothing in this subtitle shall be construed to interfere with or abridge an elder's right to practice his or her religion through reliance on prayer alone for healing when this choice—

"(i) is contemporaneously expressed, either orally or in writing, to a specific religious group or priest; and

"(ii) does not conflict with a specific illness or injury which the elder has at the time of the decision by an elder who is competent at the time of the decision;

"(C) makes such recommendations for legislation, model laws, or other action as the Council determines to be appropriate.

"(D) POWERS OF THE COUNCIL.—

"(1) INFORMATION FROM FEDERAL AGENCIES.—Subject to the requirements of section 2012(a), the Council may secure directly from any Federal department or agency such information as the Council considers necessary to carry out this section. Upon request of the Chair, the head of each Federal department or agency shall furnish such information to the Council.
(2) POSTAL SERVICES.—The Council may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

(b) TRAVEL EXPENSES.—The members of the Council shall not receive compensation for the performance of services for the Council. The members may be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Council. Notwithstanding section 1942 of title 5, United States Code, the Secretary may accept the voluntary and uncompensated services of the members of the Council.

SEC. 2023. RESEARCH PROTECTIONS.

(a) GUIDELINES.—The Secretary shall promulgate guidelines to assist researchers working in the area of elder abuse, neglect, and exploitation, with issues relating to human subject protections.

(b) DEFINITION OF LEGALLY AUTHORIZED REPRESENTATIVE FOR APPLICATION OF REGULATIONS.—For purposes of the application of subsection (a) in cases in which the person represented by the legally authorized representative is an elderly individual, the term 'legally authorized representative' means, unless otherwise provided by law, the individual or judicial or other body authorized under the applicable law to consent to medical treatment on behalf of another person.

SEC. 2024. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated such sums as are necessary to carry out this section.

SEC. 2025. ESTABLISHMENT AND SUPPORT OF ELDER ABUSE, NEGLECT, AND EXPLOITATION FORENSIC CENTERS.

(a) IN GENERAL.—The Secretary, in consultation with the Attorney General, shall make grants to eligible entities to establish and operate stationary and mobile forensic centers to develop forensic capacity, and provide services relating to, elder abuse, neglect, and exploitation.

(b) STATIONARY FORENSIC CENTERS.—The Secretary shall make grants under subsection (a) to institutions of higher education, as defined in section 101 of the Higher Education Act of 1965, to establish and operate stationary forensic centers.

(c) MOBILE CENTERS.—The Secretary shall make grants under subsection (a) to appropriate entities to establish and operate mobile forensic centers.

(d) AUTHORIZED ACTIVITIES.—An eligible entity that receives a grant under this section shall use the funds provided under this section to:

(1) establish, maintain, and operate the stationary or mobile forensic center;

(2) enter into cooperative agreements with other entities to assist in the planning, development, and operation of the forensic center;

(3) train law enforcement and other individuals in the areas of elder abuse, neglect, or exploitation, and exploitation of elder abuse, neglect, or exploitation;

(4) enter into agreements with governmental agencies or entities to share facilities and equipment; and

(5) conduct research and development.

(e) USE OF GRANT FUNDS.—An eligible entity that receives a grant under this section shall use the grant funds only for authorized activities described in subsection (d) of this section.
funds made available through the grant to assist in determining whether abuse, neglect, or exploitation occurred and whether a crime was committed and to conduct research to describe and disseminate information on—

‘‘(A) forensic markers that indicate a case in which elderly abuse, neglect, or exploitation may have occurred; and

‘‘(B) procedures for determining, in such a case, when and how health care, emergency service, social and protective services, and legal service providers should intervene and which providers should report the case to law enforcement authorities.

‘‘(2) DEVELOPMENT OF FORENSIC EXPERIENCE.—The Secretary shall make grants to entities that develop forensic expertise regarding elderly abuse, neglect, and exploitation in order to provide medical and forensic evaluation, therapeutic intervention, victim support and advocacy, case review, and case tracking.

‘‘(3) COLLECTION OF EVIDENCE.—The Secretary, in coordination with the Attorney General, shall use data made available by grant recipients under this section to develop geriatric health care professionals and law enforcement to collect forensic evidence, including collecting forensic evidence related to a potential determination of elderly abuse, neglect, or exploitation.

‘‘(e) APPLICATION.—To be eligible to receive a grant under this subsection, an entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

‘‘(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section—

‘‘(1) for fiscal year 2011, $1,000,000;

‘‘(2) for fiscal year 2012, $6,000,000; and

‘‘(3) for each of fiscal years 2013 and 2014, $8,000,000.

PART II—PROGRAMS TO PROMOTE ELDER JUSTICE

SEC. 2041. ENHANCEMENT OF LONG-TERM CARE.

(a) Grants and Incentives for Long-Term Care Staffing.—

‘‘(1) IN GENERAL.—The Secretary shall carry out activities, including activities described in paragraphs (2) and (3), to provide incentives for individuals to train for and maintain employment providing direct care in long-term care.

‘‘(2) SPECIFIC PROGRAMS TO ENHANCE TRAINING, RECRUITMENT, AND RETENTION OF STAFF.—

‘‘(A) COORDINATION WITH SECRETARY OF LABOR TO RECRUIT AND TRAIN LONG-TERM CARE STAFF.—The Secretary shall coordinate activities under this subsection with the Secretary of Labor in order to provide incentives for individuals to train for and seek employment providing direct care in long-term care.

‘‘(B) CAREER LADDERs AND WAGE OR BENEFIT INCENTIVES TO INCREASE STAFFING IN LONG-TERM CARE.—

‘‘(1) IN GENERAL.—The Secretary shall make grants to eligible entities to carry out programs through which the entities—

‘‘(I) offer, to employees who provide direct care to residents of an eligible entity or individuals receiving community-based long-term care from an eligible entity, continuing education training and varying levels of certification, based on observed clinical care practices and the amount of time the employees spend providing services; and

‘‘(II) provide, or make arrangements to provide, bonuses or other increased compensation or benefits to employees who achieve certification under such a program.

‘‘(2) APPLICATION.—To be eligible to receive a grant under this subparagraph, an eligible entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

‘‘(3) USE OF GRANT FUNDS.—Funds provided under grants made available under this subsection shall be used to provide training and technical assistance regarding management practices using methods that are demonstrated to promote retention of individuals who provide direct care.

‘‘(B) AUTHORIZED ACTIVITIES.—An eligible entity that receives a grant under subparagraph (A) shall use funds made available through the grant to provide training and technical assistance regarding management practices under this subsection with the Secretary at such time, in such manner, and containing such information as the Secretary may require.

‘‘(C) Eligible entity.—The Secretary shall make grants to eligible entities to enable the entities to provide training and technical assistance.

‘‘(D) AUTHORITY TO LIMIT NUMBER OF APPLICANTS.—The Secretary shall limit the number of applicants for a grant under this subsection.

‘‘(3) APPLICATION.—To be eligible to receive a grant under this subsection, an entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

‘‘(4) PARTICIPATION IN STATE HEALTH EXCHANGES.—A long-term care facility that receives a grant under this subsection shall, where available, participate in activities conducted by a State or a qualified State-based entity under section 3003(f) of the Public Health Service Act under a grant under section 3013 of the Public Health Service Act to coordinate care and for other purposes determined appropriate by the Secretary.

‘‘(5) Accountability Measures.—The Secretary shall develop accountability measures to ensure that the activities conducted using funds made available under this subsection help improve patient safety and reduce adverse events and health care complications resulting from medication errors.

‘‘(B) AUTHORITY TO LIMIT NUMBER OF APPLICANTS.—Nothing in this subsection shall be construed as prohibiting the Secretary from limiting the number of applicants for a grant under this subsection.

‘‘(C) ADOPTION OF STANDARDS FOR TRANSACTIONS INVOLVING CLINICAL DATA BY LONG-TERM CARE FACILITIES.—

‘‘(1) STANDARDS AND COMPATIBILITY.—The Secretary shall develop standards for the exchange of clinical data by long-term care facilities, including where available, standards for messaging and nomenclature. Standards adopted by the Secretary under the preceding sentence shall be compatible with standards established under part C of title XI, standards established under subsections (b)(2)(B)(i) and (e)(4) of section 1860D-4, standards adopted under section 3004 of the Public Health Service Act, and general health information technology standards.

‘‘(2) ELECTRONIC SUBMISSION OF DATA TO THE SECRETARY.—

‘‘(A) IN GENERAL.—Not later than 10 years after the date of enactment of the Elder Justice Act of 2009, the Secretary shall have procedures in place to accept the optional electronic submission of clinical data by long-term care facilities pursuant to the standards adopted under paragraph (1).

‘‘(B) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to require a long-term care facility to submit clinical data electronically to the Secretary.

‘‘(3) ELIGIBLE ENTITY.—The Secretary shall promulgate regulations to carry out this subsection. Such regulations shall require a
State, as a condition of the receipt of funds under this part, to conduct such data collection and reporting as the Secretary determines are necessary to satisfy the requirements of this subsection.

(‘d) Authorization of Appropriations.—There are authorized to be appropriated to carry out this section—

(1) for fiscal year 2011, $20,000,000;
(2) for fiscal year 2012, $17,500,000; and
(3) for each of fiscal years 2013 and 2014, $15,000,000.

§ 2042. ADULT PROTECTIVE SERVICES FUNCTIONs AND GRANT PROGRAMES.

(a) Secretarial Responsibilities.—

(1) In General.—The Secretary shall ensure that the Department of Health and Human Services—

(A) provides funding authorized by this part to State and local adult protective services offices that investigate reports of the abuse, neglect, and exploitation of elders;

(B) collects and disseminates data annually relating to the abuse, exploitation, and neglect of elders in coordination with the Department of Justice;

(C) develops and disseminates information on best practices regarding, and provides information on, carrying out adult protective services;

(D) conducts research related to the provision of adult protective services; and

(E) provides technical assistance to States and other entities that provide or fund the provision of adult protective services, including through grants made under subsection (b) and (c).

(2) Authorization of Appropriations.—There are authorized to be appropriated to carry out this subsection, $100,000,000 for each of fiscal years 2011 through 2014.

(b) Grants to Enhance the Provision of Adult Protective Services.—

(1) In General.—There is established an adult protective services grant program under which the Secretary shall annually award grants to States in the amounts calculated under paragraph (2) for the purposes of enhancing adult protective services provided by States and local units of government.

(2) Amount of Payment.—

(A) In General.—Subject to the availability of appropriations and subparagraphs (B) and (C), the amount paid to a State for a fiscal year under this subsection shall be

(A) equal to the amount appropriated to the Secretary, at such time and in such manner as the Secretary may require, for a grant for the purpose of providing adult protective services; and

(B) divided among the States who reside in that State.

(B) Guaranteed Minimum Payment Amount.—

(i) in States.—Subject to clause (ii), if the amount determined under subparagraph (A) for a State for a fiscal year is less than 0.75 percent of the amount appropriated for such fiscal year under this subsection, the amount paid under such subsection shall equal the amount appropriated for that fiscal year.

(ii) Territories.—In the case of a State other than one of the 50 States, clause (i) shall be applied as if each reference to ‘0.75’ were a reference to ‘0.1’.

(C) Pro rata Reductions.—The Secretary shall make such pro rata reductions to the amounts described in subparagraph (A) as are necessary to comply with the requirements of subparagraph (B).

(3) Authorized Activities.—

(A) Adult Protective Services.—Funds made available pursuant to this subsection may only be used by States and local units of government to provide adult protective services and may not be used for any other purpose.

(B) Use by Agency.—Each State receiving funds pursuant to this subsection shall provide such fiscal year, the Secretary shall increase such amount so that the total amount awarded under such subsection—

(1) for fiscal year 2011, $20,000,000;
(2) for fiscal year 2012, $17,500,000; and
(3) for each of fiscal years 2013 and 2014, $15,000,000.

§ 2043. LONG-TERM CARE OMBUDSMAN PROGRAM GRANTS AND TRAINING.

(a) Grants to Support the Long-Term Care Ombudsman Program.—

(1) In General.—The Secretary shall make grants to eligible entities for the purpose of—

(A) improving the capacity of State long-term care ombudsman programs to respond to and resolve complaints about abuse and neglect; and

(B) conducting pilot programs with State long-term care ombudsman offices or local ombudsman entities; and

(2) Authorization of Appropriations.—There are authorized to be appropriated to carry out this subsection, $7,500,000 for each of fiscal years 2011 through 2014.

§ 2044. PROVISION OF INFORMATION REGARDING, AND EVALUATIONS OF, ELDER JUSTICE PROGRAMS.

(a) Provision of Information.—To be eligible to receive a grant under this part, an applicant shall agree—

(1) except as provided in paragraph (2), to provide the eligible entity conducting an evaluation under subsection (b) of the activities funded with such information to the Secretary or the entity may require in order to conduct such evaluation; or

(2) in the case of an applicant for a grant under section 2041(b), to provide the Secretary with such information to the extent the Secretary may require to conduct an evaluation or audit under subsection (c).

(b) Use of Eligible Entities To Conduct Evaluations.—

(1) Evaluations Required.—Except as provided in paragraph (2), the Secretary shall—

(A) reserve a portion (not less than 2 percent) of the funds appropriated with respect to each program carried out under this part; and

(B) use the funds reserved under subparagraph (A) to provide assistance to eligible entities to conduct evaluations of the activities funded under each program carried out under this part.

§ 2045. ELDER JUSTICE PROGRAMS.

(a) Certification of Eligibility.—The term ‘certified Elder Justice Grant Program by the Secretary’ includes all programs to which the Secretary may certify, including programs that provide services to elders residing in the United States who reside in that State.

(b) Authorized Activities.—The recipient of a grant under paragraphs (1) and (3) of this subsection shall make grants to eligible entities for the purpose of—

(1) providing technical assistance to the Secretary or the entity conducting such evaluations; and

(2) submitting reports of the results of such evaluations to the entity conducting such evaluations.

(c) Authorization of Appropriations.—There are authorized to be appropriated to carry out this subsection, $7,500,000 for each of fiscal years 2011 through 2014.

§ 2046. EHR TECHNOLOGY GRANT PROGRAM.

(a) Provisions of Information.—To be eligible to receive a grant under this part, an applicant shall agree—

(1) to provide information to the Secretary or the entity conducting such evaluations; and

(2) to submit reports of the results of such evaluations to the Secretary or the entity conducting such evaluations.

(b) Certification of Eligibility.—The term ‘EHR Technology Grant Program by the Secretary’ includes all programs to which the Secretary may certify, including programs that provide services to elders residing in the United States who reside in that State.

(c) Authorized Activities.—The recipient of a grant under paragraphs (1) and (3) of this subsection shall make grants to eligible entities for the purpose of—

(1) providing technical assistance to the Secretary or the entity conducting such evaluations; and

(2) submitting reports of the results of such evaluations to the entity conducting such evaluations.

(d) Authorization of Appropriations.—There are authorized to be appropriated to carry out this subsection, $7,500,000 for each of fiscal years 2011 through 2014.
the funding provided under the grant is expended only for the purposes for which it is made.

(2) AUDITS.—The Secretary shall conduct appropriate audits of grants made under section 2941(b).

SEC. 2045. REPORT.


"(1) compiling, summarizing, and analyzing the information contained in the State reports submitted under subsections (b)(4) and (c)(4) of section 2042; and

"(2) containing such recommendations for legislative or administrative action as the Secretary determines to be appropriate.

SEC. 2046. RULE OF CONSTRUCTION.

"Nothing in this subtitle shall be construed as

"(1) limiting any cause of action or other relief related to obligations under this subtitle that is available under the law of any State, or political subdivision thereof; or

"(2) creating a private cause of action for a violation of this subtitle.

OPTION FOR STATE PLAN UNDER PROGRAM FOR TEMPORARY ASSISTANCE FOR NEEDY FAMILIES.

(A) IN GENERAL.—Section 402(a)(1)(B) of the Social Security Act (42 U.S.C. 602(a)(1)(B)) is amended by adding at the end the following new clause:

"(V) the extent to which such complaints are referred to law enforcement agencies.

(G) PROTECTION OF RESIDENTS OF LONG-TERM CARE FACILITIES.

(1) NATIONAL TRAINING INSTITUTE FOR SURVEYORS.—

(A) IN GENERAL.—The Secretary of Health and Human Services shall enter into a contract with an entity for the purpose of establishing and operating a National Training Institute for Federal and State surveyors. Such Institute shall provide and improve training of surveyors with respect to options to increase the efficiency and cost-effectiveness of such investigations.

(C) AUTHORIZATION.—There are authorized to be appropriated to carry out this paragraph, for the period of fiscal years 2011 through 2014, $12,000,000.

(2) GRANTS TO STATE SURVEY AGENCIES.—

(A) IN GENERAL.—The Secretary of Health and Human Services shall make grants to State agencies that perform surveys of skilled nursing facilities and nursing facilities under sections 1819 and 1919, respectively, of the Social Security Act (42 U.S.C. 1395i–3; 1395f), and making recommendations to the Secretary of Health and Human Services with respect to options to

(B) USE OF FUNDS.—A grant awarded under subparagraph (A) shall be used for the purpose of designating and implementing complaint investigations that—

(I) promptly prioritize complaints in order to ensure a rapid response to the most serious and urgent complaints;

(II) respond to complaints with optimum effectiveness and timelessness; and

(III) optimize the collaboration between local authorities, consumers, and providers, including—

(I) such State agency;

(II) the State Long-Term Care Ombudsman;

(III) local law enforcement agencies;

(IV) advocacy and consumer organizations;

(V) State aging units;

(VI) Area Agencies on Aging; and

(VII) other appropriate entities.

(C) AUTHORIZATION.—There are authorized to be appropriated to carry out this paragraph, for each of fiscal years 2011 through 2014, $5,000,000.

(3) REPORTING OF CRIMES IN FEDERALLY FUNDED LONG-TERM CARE FACILITIES.—

PART A OF TITLE XI OF THE SOCIAL SECURITY ACT (42 U.S.C. 1395 et seq., as amended by section 6005, is amended by inserting after section 1190A the following:

"REPORTING TO LAW ENFORCEMENT OF CRIMES OCCURRING IN FEDERALLY FUNDED LONG-TERM CARE FACILITIES

SEC. 1190B. (a) DETERMINATION AND NOTIFICATION.

"(1) DETERMINATION.—The owner or operator of each long-term care facility that receives Federal funds under this Act shall annually determine whether the facility received at least $10,000 in such Federal funds during the preceding year.

"(B) NOTIFICATION.—If the owner or operator determines under paragraph (1) that the facility received at least $10,000 in such Federal funds during the preceding year, such owner or operator shall annually notify each covered individual (as defined in paragraph (3)) of that individual's obligation to comply with the reporting requirements described in subsection (b).

(3) COVERED INDIVIDUAL DEFINED.—In this section, the term 'covered individual' means an individual who is a resident of, or is receiving care from, the facility.

(4) TIMING.—If the event that causes the suspicion of a crime (as defined by the law of the applicable political subdivision) against any individual who is a resident of, or is receiving care from, the facility.

(5) PENALTIES.—

"(A) IN GENERAL.—If a covered individual violates subsection (b) and the violation exacerbat...
“(ii) racial and ethnic minority populations; and
“(iii) populations underserved because of special needs (such as language barriers, disabilities, or age).
“(d) ADDITIONAL PENALTIES FOR RETALIATION.—
“(1) IN GENERAL.—A long-term care facility may not—
“(A) discharge, demote, suspend, threaten, harass, or deny a promotion or other employment-related benefit to an employee, or in any other manner discriminate against an employee in the terms and conditions of employment because of lawful acts done by the employee;
“(B) file a complaint or a report against a nurse or other employee with the appropriate State professional disciplinary agency because of lawful acts done by the nurse or employee for making a report, causing a report to be made, or for making steps in furtherance of making a report pursuant to subsection (b)(1).
“(2) PENALTIES FOR RETALIATION.—If a long-term care facility violates subparagraphs (A) or (B) of paragraph (1) the facility shall be subject to a civil money penalty of not more than $200,000 or the Secretary may classify the entity as an excluded entity for a period of 2 years pursuant to section 1128(b), or both.
“(3) REQUIREMENT TO POST NOTICE.—Each long-term care facility shall post conspicuously in the place of employment a form specified by the Secretary specifying the rights of employees under this section. Such sign shall include a statement that an employee may file a complaint with the Secretary against a long-term care facility that violates the provisions of this subsection and information with respect to the manner of filing such a complaint.
“(e) PROCEDURE.—The provisions of section 1128A (other than subsections (a) and (b) and the second sentence of subsection (f)) shall apply to a civil money penalty or exclusion under this section in the same manner as such provisions apply to a penalty or proceeding under section 1128(b).
“(f) DEFINITIONS.—In this section, the terms ‘elder justice’, ‘long-term care facility’, and ‘law enforcement’ have the meanings given to them in section 102111.
“(g) NATIONAL NURSE AIDE REGISTRY.—
“(1) DEFINITION OF NURSE AIDE.—In this subsection the term ‘nurse aide’ has the meaning given that term in sections 1819(b)(5)(F) and 1919(b)(5)(F) of the Social Security Act (42 U.S.C. 1395i–3(b)(5)(F); 1396n(b)(5)(F)).
“(2) NURSE AIDE REGISTRY.—
“(A) IN GENERAL.—The Secretary, in consultation with appropriate government agencies and private sector organizations, shall conduct a study on establishing a national nurse aide registry.
“(B) AREAS EVALUATED.—The study conducted under this subsection shall include an evaluation of—
“(i) who should be included in the registry;
“(ii) how such a registry would comply with Federal and State privacy laws and regulations;
“(iii) how data would be collected for the registry;
“(iv) what entities and individuals would have access to the data collected;
“(v) how the registry would provide appropriate information regarding violations of Federal and State law by individuals included in the registry;
“(vi) how the functions of a national nurse aide registry would be coordinated with the nationwide program for national and State背景和检查对直接患者：
“(vii) how the information included in State nurse aide registries developed and maintained under sections 1819(e)(2) and 1919(e)(2) of the Social Security Act (42 U.S.C. 1395i–3(e)(2); 1396n(3)(e)(2)) are provided as part of a national nurse aide registry.
“(C) CONSIDERATIONS.—In conducting the study and preparing the report required under this subsection, the Secretary shall take into consideration the findings and conclusions of relevant reports and other relevant resources, including the following:
“(v) The 2001 Report to CMS from the School of Rural Public Health, Texas A&M University, Preventing Abuse and Neglect in Nursing Homes: The Role of Nurse Aide Registries.
“(vi) Information included in State nurse aide registries developed and maintained under sections 1819(e)(2) and 1919(e)(2) of the Social Security Act (42 U.S.C. 1395i–3(e)(2); 1396n(3)(e)(2)).
“(D) REPORT.—Not later than 18 months after the date of enactment of this Act, the Secretary shall submit to the Elder Justice Coordinating Council established under section 2021 of the Social Security Act, as added by section 1005(a), the Committee on Finance of the Senate, and the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives a report containing the findings and recommendations of the study conducted under this paragraph.
“(E) FUNDING LIMITATION.—Funding for the study conducted under this subsection shall not exceed $500,000.
“(3) CONGRESSIONAL ACTION.—After receiving the report submitted by the Secretary under paragraph (2)(D), the Committee on Finance of the Senate and the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives shall, as they deem appropriate, take action based on the recommendations contained in the report.
“(4) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary for the purpose of carrying out this subsection.
“(d) CONFORMING AMENDMENTS.—
“(1) TITLE XX.—Title XX of the Social Security Act (42 U.S.C. 1397 et seq.), as amended by section 6703(a), is amended—
“(A) in subsection (k), by striking ‘‘TITLE’’ and inserting ‘‘subtitle’’; and
“(B) in subsection (l), by striking ‘‘title XX’’ and inserting ‘‘subtitle 1’’.
“(2) TITLE IV.—Title IV of the Social Security Act (42 U.S.C. 601 et seq.) is amended—
“(A) in section 6404(a) of this title, by inserting ‘‘subtitle 1’’ and ‘‘subtitle 2’’ after ‘‘title XX’’; and
“(B) in each place it appears.

Subtitle I—Sense of the Senate Regarding Medical Malpractice

SEC. 8801. SENSE OF THE SENATE REGARDING MEDICAL MALPRACTICE.

It is the sense of the Senate that—

(1) health care reform presents an opportunity to address issues related to medical malpractice and medical liability insurance;

(2) States should be encouraged to develop and test alternatives to the existing civil litigation system as a way of improving patient safety, reducing medical errors, encouraging the efficient resolution of disputes, increasing the availability of prompt and fair resolution of disputes, and improving access to liability insurance, while preserving an individual’s right to seek redress in court; and

(3) Congress should consider establishing a State demonstration program to evaluate alternative mechanisms to the existing civil litigation system with respect to the resolution of medical malpractice claims.

TITLE VII—IMPROVING ACCESS TO INNOVATIVE MEDICAL THERAPIES

Subtitle A—Biologics Price Competition and Innovation

SEC. 7001. SHORT TITLE.

(a) IN GENERAL.—This subtitle may be cited as the ‘‘Biologics Price Competition and Innovation Act of 2009’’.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that a biosimilars pathway harmonizing consumer interests and ensuring consistency should be established.

SEC. 7002. APPROVAL PATHWAY FOR BIOSIMILAR BIOLOGICAL PRODUCTS.

(a) LICENSURE OF BIOLOGICAL PRODUCTS AS BIOSIMILAR OR INTERCHANGEABLE.—Section 351 of the Public Health Service Act (42 U.S.C. 262) is amended—

(1) in subsection (a)(1)(A), by inserting ‘‘under this subsection or subsection (k)’’ after ‘‘biosimilars license’’; and

(2) by adding at the end the following:

‘‘(k) LICENSURE OF BIOLOGICAL PRODUCTS AS BIOSIMILAR OR INTERCHANGEABLE.—

‘‘(1) IN GENERAL.—Any person may submit an application for licensure of a biological product under this subsection.

‘‘(2) CONTENT.—

‘‘(A) IN GENERAL.—

‘‘(i) REQUIRED INFORMATION.—An application submitted under this subsection shall include information demonstrating that—

‘‘(I) the biological product is biosimilar to a reference product based upon data derived from analytical studies that demonstrate—

‘‘(aa) analytical studies that demonstrate that the biological product is highly similar to the reference product notwithstanding minor differences in clinically inactive components;

‘‘(bb) animal studies (including the assessment of immunogenicity and pharmacokinetics or pharmacodynamics) that
(B) One Reference Product per Application.—A biological product, in an application submitted under this subsection, may not be evaluated against more than 1 reference product.

(B) Review.—An application submitted under this subsection shall be reviewed by the Center for Biologics Evaluation and Research Administration that is responsible for the review and approval of the application under which the reference product is licensed.

(1) Determination by Secretary.—The Secretary may determine, in the Secretary’s discretion, that an element described in subsection (k) or one of the elements described in paragraph (4), and therefore is interchangeable biosimilar biological product.

(II) the biological product and reference product is manufactured, processed, packed, or held meets standards designed to assure that the biological product continues to be safe, pure, and potent; and

(i) the facility in which the biological product is manufactured, processed, packed, or held meets standards designed to assure that the biological product continues to be safe, pure, and potent; and

(ii) the standards described in paragraph (4), and therefore is interchangeable biological product.

(ii) the biological product and reference product is licensed under this subsection.

(i) the standards described in paragraph (4), and therefore is interchangeable biological product.

(II) the biological product and reference product is licensed under this subsection.

(i) the facility in which the biological product is manufactured, processed, packed, or held meets standards designed to assure that the biological product continues to be safe, pure, and potent; and

(ii) the standards described in paragraph (4), and therefore is interchangeable biological product.

(iii) the facility in which the biological product is manufactured, processed, packed, or held meets standards designed to assure that the biological product continues to be safe, pure, and potent; and

(iv) the standards described in paragraph (4), and therefore is interchangeable biological product.

(III) The route of administration, the dosage form, and the strength of the biological product are the same as those of the reference product.

(IV) The facility in which the biological product is manufactured, processed, packed, or held meets standards designed to assure that the biological product continues to be safe, pure, and potent; and

(V) may include any additional information in support of the application, including publicly-available information with respect to the reference product or another biological product.

(B) Interchangeability.—An application (or a supplement to an application) submitted under this subsection, an application submitted under this subsection, may include in the application information demonstrating that the biological product meets the standards described in paragraph (4).

(5) Evaluation by Secretary.—Upon review of an application (or a supplement to an application) submitted under this subsection, the Secretary shall license the biological product described in paragraph (4) if—

(A) the Secretary determines that the information submitted in the application (or the supplement to such application) is sufficient to show that the biological product—

(i) is biosimilar to the reference product; and

(ii) meets the standards described in paragraph (4), and therefore is interchangeable with the reference product; and

(iii) can be expected to produce the same clinical result as the reference product in any given patient; and

(B) for a biological product that is administered to individual patients, the risk in terms of safety or diminished efficacy of alternating or switching between use of the biological product and the reference product is not greater than the risk of using the reference product without such alternation or switch.

(6) Exclusivity for First Interchangeable Biological Product.—Upon review of an application submitted under this subsection, the Secretary may determine whether the biological product is a first interchangeable biological product.

(7) Exclusivity for Reference Product.—

(1) Effective Date of Biosimilar Approval.—Approval of an application under this subsection may not be made effective by the Secretary until the date that is 12 years after the date on which the reference product was first licensed under subsection (a).

(2) Filing Period.—An application submitted under this subsection may not be approved by the Secretary until the date that is 4 years after the date on which the biological product was first licensed under subsection (a).

(3) First License.—Subparagraphs (A) and (B) shall not apply to a license for or approval of—

(i) a supplement for the biological product that is the reference product; or

(ii) a subsequent application filed by the same sponsor or manufacturer of the biological product that is the reference product (or a licensor, predecessor in interest, or other related entity) for—

(i) a change (not including a modification to the structure of the biological product) that results in a new indication, route of administration, dosage form, delivery system, delivery device, or strength; or

(ii) a modification to the structure of the biological product that does not result in a change in safety, purity, or potency.

(8) Guidance Documents.—

(A) In General.—The Secretary shall provide the public an opportunity to comment on any proposed guidance issued under subparagraph (A) before issuing final guidance.

(B) Review.—An application submitted under this subsection may not be reviewed against more than 1 reference product.

(C) No Requirement for Application Consideration.—The Secretary shall establish a process through which the public may provide the Secretary with input regarding proposed and final guidance.

(9) Requirement for Product Class-Specific Guidance.—If the Secretary issues product class-specific guidance under subparagraph (A), such guidance shall include a description of—

(i) the criteria that the Secretary will use to determine whether a biological product is highly similar to a reference product in such product class; and

(ii) the criteria, if available, that the Secretary will use to determine whether a biological product is highly similar to a reference product in such product class;

(A) in general. The Secretary may indicate in a guidance document that the science and experience, as of the date of such guidance document, support the issuance of a guidance document for any condition of use, the Secretary will use to determine whether a biological product is highly similar to a reference product in such product class (not including any recombinant protein) does not allow approval of an application for a license as provided under this subsection for such product or product class.

(10) Modification or Reversal. The Secretary may issue a subsequent guidance document under subparagraph (A) to modify or reverse a guidance document under clause (i).

(B) Certain Product Classes. The Secretary may indicate in a guidance document that science and experience, as of the date of such guidance document, support the issuance of a guidance document for any condition of use, the Secretary will use to determine whether a biological product is highly similar to a reference product in such product class (not including any recombinant protein) does not allow approval of an application for a license as provided under this subsection for such product or product class.

(C) No Effect on Ability to Deny License. Clause (i) shall not be construed to require the Secretary to approve a product with respect to which the Secretary has not indicated in a guidance document that the science and experience, as described in clause (i), does not allow approval of such an application.

(D) Patents. The Secretary shall apply to the exchange of information described in this subsection.

(1) Confidential Access to Subsection (k) Application.—Unless otherwise agreed to by a person that submits an application under subsection (k) (referred to in this subsection as the ‘subsection (k) applicant’) and the sponsor of the application for the reference product (referred to in this subsection as the ‘reference product sponsor’), the provisions of this paragraph shall apply to the exchange of information described in this subsection.

(2) In General.—
“(I) Provision of Confidential Information.—When a subsection (k) applicant submits an application under subsection (k), such applicant shall provide to the persons described in subparagraph (A) of this paragraph, in a manner and in the form specified in subsection (k), all information that is the subject of the subsection (k) application and is the subject of the application for patent protection, with respect to each patent listed by the subsection (k) applicant. By providing the confidential information described in clause (ii), subject to the terms and conditions applicable to the party obtaining such information, such applicant shall provide to the persons described in clause (ii) all information that is the subject of the subsection (k) application and is the subject of the application for patent protection, with respect to each patent listed by the subsection (k) applicant.

“(II) Outside Counsel.—One or more attorneys designated by the reference product sponsor who are employees of an entity other than the reference product sponsor (referred to in this paragraph as the ‘outside counsel’), provided that such attorneys do not engage, formally or informally, in patent prosecution, the representation of the outside counsel in a manner and in the form specified in subsection (k), all information that is the subject of the subsection (k) application and is the subject of the application for patent protection, with respect to each patent listed by the subsection (k) applicant. By providing the confidential information described in clause (iii), subject to the terms and conditions applicable to the party obtaining such information, such applicant shall provide to the parties all information that is the subject of the subsection (k) application and is the subject of the application for patent protection, with respect to each patent listed by the subsection (k) applicant.

“(III) In-House Counsel.—One attorney that represents the reference product sponsor who is an employee of the reference product sponsor, or an attorney designated by the reference product sponsor (referred to in this paragraph as the ‘in-house counsel’), provided that such attorneys do not engage, formally or informally, in patent prosecution, the representation of the in-house counsel in a manner and in the form specified in subsection (k), all information that is the subject of the subsection (k) application and is the subject of the application for patent protection, with respect to each patent listed by the subsection (k) applicant. By providing the confidential information described in clause (iv), subject to the terms and conditions applicable to the party obtaining such information, such applicant shall provide to the parties all information that is the subject of the subsection (k) application and is the subject of the application for patent protection, with respect to each patent listed by the subsection (k) applicant.

“(IV) Patent Owner Access.—A representative of the owner of a patent exclusively licensed to a reference product sponsor, or an attorney designated by the owner of a patent, provided that such attorneys do not engage, formally or informally, in patent prosecution, the representation of the patent owner in a manner and in the form specified in subsection (k), all information that is the subject of the subsection (k) application and is the subject of the application for patent protection, with respect to each patent listed by the subsection (k) applicant. By providing the confidential information described in clause (v), subject to the terms and conditions applicable to the party obtaining such information, such applicant shall provide to the parties all information that is the subject of the subsection (k) application and is the subject of the application for patent protection, with respect to each patent listed by the subsection (k) applicant.

“(V) Limitation on Disclosure.—No person that receives confidential information pursuant to subparagraph (B) shall disclose any confidential information to any other person or entity, including the reference product sponsor employees, outside scientific consultants, or other outside counsel retained by the reference product sponsor, without the prior written consent of the subsection (k) applicant, which shall not be unreasonably withheld.

“(VI) Use of Confidential Information.—Confidential information shall be used for the sole purpose of patent prosecution, with respect to each patent assigned to or exclusively licensed by the reference product sponsor, whether a claim of patent infringement could reasonably be asserted by the reference product sponsor or the outside counsel any interest in or license to use the confidential information, for purposes other than those specified in subparagraph (D).

“(F) Effect of Infringement Action.—In the event that the reference product sponsor files a patent infringement suit, the use of confidential information shall continue to be governed by the terms of this paragraph until such time as a court enters a protective order regarding the information. Upon entry of such order, subsection (k) applicant may reclassify confidential information in accordance with the terms of that order. No confidential information shall be included in any publicly-available complaint or other pleading. In the event that the reference product sponsor does not file an infringement suit, the information described in paragraph (6) shall not be subject to the terms and conditions specified in subparagraph (B).

“(G) Obligation of Construction.—Nothing in this paragraph shall be construed—

“(i) as an admission by the subsection (k) applicant that the reference product and any other biological product that is the subject of the subsection (k) application is the subject of the reference product sponsor’s patent, or

“(ii) as an admission or agreement by the subsection (k) applicant with respect to the commercial marketing of the biological product that is the subject of the subsection (k) application.

“(H) Effect of Violation.—The disclosure of any confidential information in violation of this paragraph shall be deemed to cause the subsection (k) applicant to suffer irreparable harm for which there is no adequate legal remedy and the court shall consider whether an order should be entered—

“(i) by the subsection (k) applicant to suffer irreparable harm for which there is no adequate legal remedy and the court shall consider whether an order should be entered—

“(A) provision of confidential information without the prior written consent of the subsection (k) applicant, which shall not be unreasonably withheld, to the subsection (k) applicant, the reference product sponsor, or to counsel any interest in or license to use the confidential information.

“(B) disclosure of confidential information to the subsection (k) applicant or to counsel any interest in or license to use the confidential information.

“(C) retention of a right to assert the patent or paragraph (A) or listed by the subsection (k) applicant under clause (i)—

“(i) a detailed statement that describes, on a claim by claim basis, the factual and legal basis for the belief that the subsection (k) applicant believes a claim of patent infringement under paragraph (k) is being asserted by the subsection (k) applicant; or

“(ii) a statement that the subsection (k) applicant does not intend to begin commercial marketing of the biological product that is the subject of the subsection (k) application; or

“(III) prohibit the subsection (k) applicant from engaging in any action or failure to engage in any action for patent infringement under paragraph (k).
(2) A Preliminary Injunction.—After receiving the notice under subparagraph (A) and before such date of the first commercial marketing of such biological product, the reference product sponsor may seek a preliminary injunction prohibiting the subsection (k) applicant from engaging in the commercial manufacture or sale of such biological product until the court decides the issue of patent validity, enforceability, and infringement with respect to any patent that—

(i) is identified, as applicable, in the list described in paragraph (3)(A), or

(ii) is not included, as applicable, on—

(A) the list of patents described in paragraph (4); or

(B) the lists of patents described in paragraph (5); and

(3) A Subsection (k) Application Provided.—If a subsection (k) applicant fails to complete an action required under subparagraph (A), the reference product sponsor, but not the subsection (k) applicant, may bring an action under section 2201 of title 28, United States Code, for a declaration of infringement, validity, or enforceability of any patent that is described in clauses (i) and (ii) of paragraph (8)(B).

(4) Subsequent Failure to Act by Subsection (k) Applicant.—If a subsection (k) applicant fails to complete an action required under subparagraph (A), including as provided under paragraph (3)(A), the reference product sponsor, but not the subsection (k) applicant, may bring an action under section 2201 of title 28, United States Code, for a declaration of infringement, validity, or enforceability of any patent that claims the biological product or a use of the biological product.

(5) Notice of Commercial Marketing and Preliminary Injunction.—

(A) Notice of Commercial Marketing.—The subsection (k) applicant shall provide notice to the reference product sponsor not later than 180 days before the date of the first commercial marketing of such biological product, the reference product sponsor shall provide notice to the subsection (k) applicant, and the subsection (k) applicant shall provide a statement to the reference product sponsor in accordance with paragraph (5)(B), and such statement shall be subject to paragraph (8).

(B) Preliminary Injunction.—After receiving the notice under subparagraph (A) and before such date of the first commercial marketing of such biological product, the reference product sponsor may seek a preliminary injunction prohibiting the subsection (k) applicant from engaging in the commercial manufacture or sale of such biological product until the court decides the issue of patent validity, enforceability, and infringement with respect to any patent that—

(i) is included in the list provided by the reference product sponsor under paragraph (3)(A), or

(ii) is not included, as applicable, on—

(A) the list of patents described in paragraph (4); or

(B) the lists of patents described in paragraph (5).
using, offering to sell, selling, or importation into the United States of the biological product that is the subject of the action infringed the patent, shall be a reasonable royalty.

"(C) The owner of a patent that should have been included in the list described in section 351(l)(3)(A) of the Public Health Service Act (as added by this Act) and was not timely included in such list, may not bring an action under this section for infringement of the patent with respect to the biological product."

(2) CONFORMING AMENDMENT UNDER TITLE 28.—Section 2201(b) of title 28, United States Code, is amended by inserting before the period at the end of the first sentence the following: ‘‘, or section 351 of the Public Health Service Act’’.

(3) CONFORMING AMENDMENT TO THE FEDERAL SOCIETY FOR BIOLOGICAL PRODUCTS ACT.—(a) Section 506B of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(b)(5)(B)) is amended by inserting before the period at the end of the first sentence the following: ‘‘, or with respect to the active ingredient under this section.’’

(b) Section 505B of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355c) is amended by adding at the end of subparagraph (E) the following:

(1) APPLICATION OF CERTAIN PROVISIONS.—(I) Section 351 of the Public Health Service Act (42 U.S.C. 262) (as amended by this Act).

(2) ALTERATION OF USER FEES.—If the audit performed under clause (1) indicates that the ratios compared under clause (2) (of which the Federal Trade Commission is required to make at least biennially) are no longer valid, the Comptroller General of the United States shall review and, as appropriate, adjust the user fees in order to more appropriately account for the costs of reviewing such applications. Such adjustment shall be based on recommendations approved by the Comptroller General of the United States under section 351(l) of title 31, United States Code, to ensure the validity of any potential variability.

(1) APPLICATION OF CERTAIN PROVISIONS.—The provisions of subsections (a), (d), (e), (f), (i), (j), (k), (l), (p), and (q) of section 506A of the Federal Food, Drug, and Cosmetic Act (as added by this Act) shall apply with respect to the extension of a period under paragraphs (2) and (3) to the same extent and in the same manner as such provisions apply with respect to the extension of a period under subsection (b) or (c) of section 506A of the Federal Food, Drug, and Cosmetic Act.

(2) MARKET EXCLUSIVITY FOR NEW BIOLOGICAL PRODUCTS.—If, prior to approval of an application that is submitted under subsection (a) (relating to the use of a new biological product in the pediatric population may produce health benefits in that population, the Secretary makes a written request for pediatric studies (which shall include a timeframe for completing such studies), the applicant agrees to the request, such studies are completed according to appropriate formulas, and any studies are requested within any such timeframe, and the reports thereof are submitted and accepted in accordance with such studies.
(B) if the biological product is designated under section 526 for a rare disease or condition, the period for such biological product referred to in section 527(a) is deemed to be 7 years rather than 7 years and 6 months rather than 7 years and 12 months; and

(2) the 12-year period described in subsection (k)(7) of such section 527 is deemed to be 12 years and 6 months rather than 12 years.

(2) STUDIES REGARDING PEDIATRIC USE.—

(A) PROGRAM FOR PEDIATRIC STUDY OF DRUGS.—Subsection (a)(1) of section 409I of the Public Health Service Act (42 U.S.C. 264m) is amended by inserting "biological products", purchasing directly from a manufacturer

(B) INSTITUTE OF MEDICINE STUDY.—Section 505(a)(p) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355b(p)) is amended by striking paragraphs (4) and (5) and inserting the following:

(4) review and assess the number and importance of biological products for children that are being tested for pediatric use; and

(5) recommend actions necessary to ensure access to drug discount pricing under this section (or an amendment made by this Act) has been designated under section 351 of the Public Health Service Act (42 U.S.C. 262) (as amended under section 1886(d)(1)(B)(v) of the Social Security Act, or a free-standing cancer hospital excluded from the Medicare prospective payment system pursuant to section 1886(d)(1)(B)(v) of the Social Security Act, that would meet the requirements of subparagraph (A) or a diversion prohibition under clause (ii) of such subparagraph, if the hospital were a subsection (d) hospital as defined by section 1886(d)(1)(B) of the Social Security Act.

(5) An entity that is a rural referral center, as defined by section 1886(d)(5)(C)(i) of the Social Security Act, or a sole community hospital, as defined by section 1886(d)(5)(C)(ii) of such act, and that meets the requirements of subparagraph (L)(i), has a disproportionate share adjustment percentage equal to or greater than 8 percent.

(6) EXTENSION OF DISCOUNT TO INPATIENT DRUGS.—Section 340B of the Public Health Service Act (42 U.S.C. 256b) is amended—

(1) in paragraphs (2), (5), (7), and (9) of subsection (a), by striking "outpatient" each place it appears; and

(2) in subsection (b)—

(A) by striking "OTHER DEFINITION" and all that follows through 'in this section' and inserting the following: "OTHER DEFINITIONS.—

(1) IN GENERAL.—In this section; and

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

(2) COVERED DRUG.—In this section, the term 'covered drug'—

(A) means a covered outpatient drug (as defined in section 297(k)(2) of the Social Security Act); and

(B) includes, notwithstanding paragraph (3) of section 297(k) of such Act, a drug used in an inpatient or outpatient service provided by a hospital described in paragraph (L), (M), (N), or (O) of subsection (a)(4) that is enrolled to participate in the drug discount program under this section; and

(C) PROHIBITION ON GROUP PURCHASING ARRANGEMENTS.—Section 340B(a)(4) of the Public Health Service Act (42 U.S.C. 256b(a)(4)) is amended—

(1) in paragraph (d), in clause (1), by adding "and" at the end;

(2) in clause (1), by striking "; and" and inserting a period; and

(C) by striking clause (ii) and

(2) in paragraph (5), as amended by subsection (b)—

(1) MANUFACTURER COMPLIANCE,—
“(A) IN GENERAL.—From amounts appropriated under paragraph (4), the Secretary shall provide for improvements in compliance by manufacturers with the requirements under subsection (a)(1) and charged to covered entities, with the following:

(1) The development of a system to enable the Secretary to verify the accuracy of ceiling prices calculated by manufacturers under subsection (a)(1) and charged to covered entities, with the following:

(I) Developing and publishing through an appropriate policy or regulatory issuance, precisely defined standards and methodology for the verification of ceiling prices under such subsection.

(II) Comparing regularly the ceiling prices calculated by the Secretary with the quarterly pricing data that is reported by manufacturers to the Secretary.

(III) Performing spot-checks of sales transactions by covered entities.

(IV) The cause of any pricing discrepancies that may be identified and either taking, or requiring manufacturers to take, such corrective action as is appropriate in response to such discrepancies.

(2) The establishment of procedures for manufacturers to issue refunds to covered entities in the event that there is an overcharge, to the manufacturers, including the following:

(I) Providing the Secretary with an explanation of how and why the overcharge occurred, how the refunds will be calculated, and to whom the refunds will be issued.

(II) Oversight by the Secretary to ensure that such refunds are issued accurately and within a reasonable period of time, both in routine instances of retroactive adjustment to relevant pricing data and exceptional circumstances such as erroneous or intentional overcharging for covered drugs.

(iii) The provision of access through the Internet website of the Department of Health and Human Services to the applicable ceiling prices for covered drugs as calculated and verified by the Secretary in accordance with this section, in a manner (such as through a secure word protected site) to prevent limits such access to covered entities and adequately assures security and protection of such pricing data from unauthorized re-disclosure.

(iv) The development of a mechanism by which:

(I) Rebates and other discounts provided by manufacturers to other purchasers subsequent to the sale of covered drugs to covered entities are reported to the Secretary; and

(II) Appropriate credits and refunds are issued to covered entities if such discounts or rebates have the effect of lowering the applicable ceiling price for the relevant quarter for the drugs involved.

(v) Selective auditing of manufacturers and wholesalers to ensure the integrity of the drug discount program under this section.

(vi) The imposition of sanctions in the form of civil monetary penalties, which—

(I) shall be assessed according to standards established in regulations to be promulgated by the Secretary not later than 180 days after the date of enactment of the Patient Protection and Affordable Care Act; and

(II) shall not exceed $5,000 for each instance of overcharging a covered entity that may have occurred; and

(iii) Application to any manufacturer with an agreement under this section to promptly and intentionally charges a covered entity a price for purchase of a drug that exceeds the maximum applicable price under subsection (a)(1).

(2) COVERED ENTITY COMPLIANCE.—

(A) IN GENERAL.—From amounts appropriated under paragraph (4), the Secretary shall provide for improvements in compliance by covered entities with the requirements of this section in order to prevent discrepancies in the calculation of the applicable discount provision and other requirements specified under subsection (a)(5).

(B) IMPROVEMENTS.—The improvements described in subparagraph (A) shall include the following:

(i) The development of procedures to enable covered entities to readily and regularly update (at least annually) the information on the Internet website of the Department of Health and Human Services relating to all covered drugs.

(ii) The development of a system for the Secretary to verify the accuracy of information regarding covered entities that is listed on the website described in clause (i).

(iii) The development of more detailed guidance describing methodologies and options available to covered entities for billing disputes and claims under subsections (a)(4)(A) and (a)(4)(B) in a manner that avoids duplicate discounts pursuant to subsection (a)(5)(A).

(iv) The establishment of a single, universal and uniform system for the calculation of ceiling prices for covered drugs in accordance with paragraph (1), through one or more of the following actions:

(I) Where a covered entity knowingly and intentionally violates subsection (a)(5)(B), the covered entity shall be required to pay a monetary penalty to a manufacturer or manufacturer in the form of interest on sums for which the covered entity is found liable under subsection (a)(5)(E), such interest to be compounded monthly and equal to the current short term interest rate as determined by the Federal Reserve for the time period for which the covered entity is liable.

(II) Where the Secretary determines that a violation of subsection (a)(5)(B) was systematic and egregious as well as knowing and intentional, removing the covered entity from the drug discount program under this section and disqualifying the entity from re-entry into such program for a reasonable period of time to be determined by the Secretary.

(III) Referring matters to appropriate Federal authorities, such as the Food and Drug Administration, the Office of Inspector General of Department of Health and Human Services, or other Federal agencies for consideration of appropriate action under other Federal statutes, such as the Prescription Drug Marketing Act (21 U.S.C. 333).

(3) ADMINISTRATIVE DISPUTE RESOLUTION PROCESS.—

(A) IN GENERAL.—Not later than 180 days after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary shall promulgate regulations to establish and implement an administrative process for the resolution of claims by covered entities that they have been overcharged for drugs purchased under this section, and claims by manufacturers, after the conduct of audits as authorized by subsection (a)(5)(D), of violations of subsections (a)(5)(B) and (a)(5)(D) and any appropriate procedures for the provision of remedies and enforcement of determinations made pursuant to such process through mechanisms and sanctions described in paragraphs (1)(B) and (2)(B).

(B) DEADLINES AND PROCEDURES.—Regulations promulgated by the Secretary under subparagraph (A) shall—

(i) designate or establish a decision-making official or decision-making body within the Department of Health and Human Services to be responsible for reviewing and finally resolving claims by covered entities that they have been charged prices for covered drugs in excess of the applicable ceiling price as described in subsection (a)(1), and claims by manufacturers that violations of subsection (a)(5)(B) and (a)(5)(D) have occurred, how the refunds will be calculated, and procedures as may be necessary to ensure that claims shall be resolved fairly, efficiently, and expeditiously;

(ii) establish procedures by which a covered entity may discover and obtain such information and documents from manufacturers and third parties as may be relevant to demonstrate the merits of a claim that charges for a manufacturer’s product have exceeded the applicable ceiling price under subsection (a)(5)(B) or (a)(5)(D) and may submit such documents and information to the administrative official or body responsible for adjudicating such claims;

(iii) require that a manufacturer conduct an audit of a covered entity pursuant to subsection (a)(5)(D) as a prerequisite to initiating administrative dispute resolution procedures as described in paragraph (B) and any appropriate procedures for the provision of remedies and enforcement of determinations available to covered entities for billing disputes and claims brought by more than one manufacturer against the same covered entity where, in the judgment of such official or body, consolidated claims are appropriate and consistent with the goals of fairness and economy of resources; and

(vi) include provisions and procedures to permit multiple covered entities to jointly assert claims of overcharges by the same manufacturer for the same drug or drugs in one administrative proceeding, and permit such claims to be asserted on behalf of covered entities by associations or organizations representing the interests of such covered entities and of which the covered entities are members.

(C) FINALITY OF ADMINISTRATIVE RESOLUTION.—The administrative resolution of a claim or claims under the regulations promulgated by the Secretary under subsection (a)(5)(E) shall be a final agency decision and shall be binding upon the parties involved, unless invalidated by an order of a court of competent jurisdiction.

(4) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection, such sums as may be necessary for fiscal years 2010 and each succeeding fiscal year.”;

(b) CONFORMING AMENDMENTS.—Section 362(a)(6) of the Public Health Service Act (42 U.S.C. 265(a)) is amended—

(1) in subsection (a)(1), by adding at the end the following: “Each such agreement shall require that the manufacturer furnish the Secretary with reports, on a quarterly basis, of the price for each covered drug subject to the agreement that, according to the manufacturer, represents the maximum price that covered entities may permissibly be required to pay for the drug (referred to in this section as the ‘ceiling price’), and shall state that the maximum price is at or below the applicable ceiling price at the time of purchase at or below the applicable ceiling price if such drug is made available to any other purchasers at such maximum price.”;

(2) in the first sentence of subsection (a)(5)(E), as redesignated by section 7101(c),
by inserting ‘‘after audit as described in subparagraph (D) and ‘‘finds.’’.

SEC. 7601. SHORT TITLE OF TITLE.

This title may be cited as the ‘‘Community Living Assistance Services and Supports Act’’ or the ‘‘CLASS Act’’.

SEC. 7602. ESTABLISHMENT OF NATIONAL VOLUNTARY INSURANCE PROGRAM FOR PURCHASING COMMUNITY LIVING ASSISTANCE SERVICES AND SUPPORTS

(a) ESTABLISHMENT OF CLASS PROGRAM.—

(1) IN GENERAL.—The Public Health Service Act (42 U.S.C. 201 et seq.), as amended by section 3204(a), is amended by adding at the end of the following:

'TITLE XXXII—COMMUNITY LIVING ASSISTANCE SERVICES AND SUPPORTS

SEC. 3201. PURPOSE.

The purpose of this title is to establish a national voluntary insurance program for purchasing community living assistance services and supports in order to—

(1) address the Nation’s community living assistance services and supports needs;

(2) establish an infrastructure that will help address the Nation’s community living assistance services and supports needs;

(3) alleviate burdens on family caregivers; and

(4) address institutional bias by providing a financing mechanism that supports personal choice and independence to live in the community.

SEC. 3202. DEFINITIONS.

In this title—

(1) ACTIVE ENROLLEE.—The term ‘‘active enrollee’’ means an individual who is enrolled in the CLASS program in accordance with section 3204 and has paid any premiums due to maintain such enrolment.

(2) ACTIVELY EMPLOYED.—The term ‘‘actively employed’’ means an individual who—

(A) is reporting for work at the individual’s usual place of employment or at another location to which the individual is required to travel because of the individual’s employment; or

(B) is a member of the uniformed services, on active duty and is physically able to perform the duties of the individual’s position; and

(3) ACTIVITIES OF DAILY LIVING.—The term ‘‘activities of daily living’’ means each of the following activities specified in section 7702B(h)(2)(B) of the Internal Revenue Code of 1986:

(A) Eating.

(B) Dressing.

(C) Transferring.

(D) Bathing.

(E) Dressing.

(F) toileting.

(4) CLASS PROGRAM.—The term ‘‘CLASS program’’ means the program established under this title.

(5) ELIGIBILITY ASSESSMENT SYSTEM.—The term ‘‘Eligibility Assessment System’’ means the entity established by the Secretary under section 3205(a)(2) to make functional eligibility determinations for the CLASS program.

(6) ELIGIBLE BENEFICIARY.—

(A) IN GENERAL.—The term ‘‘eligible beneficiary’’ means any individual who is an active enrollee as defined in subparagraph (B) and, as of the date described in subparagraph (B)—

(i) has paid premiums for enrollment in such program for at least 6 consecutive months;

(ii) has paid premiums, with respect to at least 3 calendar years that occur during the first 60 months for which the individual has paid premiums for enrollment in such program, at least an amount equal to the amount of wages and self-employment income which an individual must have in order to be credited with a quarter of coverage under section 213(d) of the Social Security Act for the year; and

(iii) has paid premiums for enrollment in such program for at least 24 consecutive months, if a lapse in premium payments of more than 3 months has occurred during the period that begins on the date of the individual’s enrollment and ends on the date of such determination.

(B) DATE DESCRIBED.—For purposes of subparagraph (A), the date described in this subparagraph is the date on which the individual is determined to have a functional limitation described in section 3203(a)(1)(C) that is expected to last for a continuous period of more than 90 days.

(C) REGULATIONS.—The Secretary shall promulgate regulations specifying exceptions to the minimum earnings requirements under subparagraph (A)(ii) for purposes of being considered an eligible beneficiary for certain populations.

(7) HOSPITAL; NURSING FACILITY; INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED; INSTITUTION FOR MENTAL DISABILITIES.—The terms ‘‘hospital’’, ‘‘nursing facility’’, ‘‘intermediate care facility for the mentally retarded’’, and ‘‘institution for mental diseases’’ have the meanings given such terms for purposes of Medicaid.

(8) CLASS INDEPENDENCE ADVISORY COUNCIL.—

The term ‘‘CLASS Independence Advisory Council’’ or ‘‘Council’’ means the Advisory Council established under section 3207 to advise the Secretary.

(9) CLASS INDEPENDENCE BENEFIT PLAN.—

The term ‘‘CLASS Independence Benefit Plan’’ means the benefit plan developed and designated by the Secretary in accordance with section 3208.

(10) CLASS INDEPENDENCE FUND.—The term ‘‘CLASS Independence Fund’’ or ‘‘Fund’’ means the fund established under section 3206.

(11) MEDICAID.—The term ‘‘Medicaid’’ means the program established under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(12) POVERTY LINE.—The term ‘‘poverty line’’ has the meaning given that term in section 6A(c)(1)(B) of the Social Security Act (42 U.S.C. 9902(c)(1)).

(13) PROTECTION AND ADVOCACY SYSTEM.—

The term ‘‘Protection and Advocacy System’’ means each system for the provision of advocacy services that is established under section 130b of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 1594d).

SEC. 7603. CLASS INDEPENDENCE BENEFIT PLANS.

(a) PROCESS FOR DEVELOPMENT.—

(1) IN GENERAL.—The Secretary, in consultation with appropriate actuaries and other experts, shall develop at least 3 actuarially sound benefit plans as alternatives for consideration for designation by the Secretary as the CLASS Independence Benefit Plan under which eligible beneficiaries shall receive benefits under this title. Each of the plan alternatives developed shall be designed to provide eligible beneficiaries with the benefits described in section 3205 consistent with the following requirements:

(A) PREMIUMS.—

(i) IN GENERAL.—Beginning with the first year of the CLASS program, and for each year thereafter, and (iii), the Secretary shall establish all premiums to be paid by enrollees for the year based on an actuarial analysis of the 75-year cost of the program that guarantees solvency throughout such 75-year period.

(ii) NOMINAL PREMIUM FOR POOREST INDIVIDUALS AND FULL-TIME STUDENTS.—

(1) IN GENERAL.—The monthly premium for enrollment in the CLASS program shall not exceed the applicable dollar amount per month determined under subclause (II) for—

(A) any individual whose income does not exceed the poverty line; and

(bb) any individual who has not attained age 22, and is actively employed during any period in which the individual is a full-time student (as determined by the Secretary).

(2) APPLICABLE DOLLAR AMOUNT.—The applicable dollar amount described in this subclause is the amount equal to $5, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for each year occurring after 2009 and before such year.

(3) CLASS INDEPENDENCE FUND RESERVES.—At such time as the CLASS program has been in operation for 10 years, the Secretary shall establish all premiums to be paid by enrollees for the year based on an actuarial analysis that accumulated reserves in the CLASS Independence Fund would not decrease in that year. At such time as the Secretary determines the CLASS program demonstrates a sustained ability to finance expected yearly expenses with expected yearly premiums and interest credited to the CLASS Independence Fund, the Secretary may decrease the required amount of CLASS Independence Fund reserves.

(4) VESTING PERIOD.—A 5-year vesting period for eligibility for benefits.

(C) BENEFIT TRIGGERS.—A benefit trigger for provision of benefits that requires a determination that an individual has a functional limitation, as certified by a licensed health care practitioner, described in any of the following clauses that is expected to last for a continuous period of more than 90 days:

(i) The individual is determined to be unable to perform at least the minimum number of activities of daily living as are required under the plan for the provision of benefits without substantial assistance (as defined by the Secretary) for a continuous period of more than 90 days:

(ii) The individual requires substantial supervision to protect the individual from
threats to health and safety due to substan-
tial cognitive impairment.

‘‘(iii) The individual has a level of func-
tional limitation similar (as determined under regulations prescribed in claus-
us (i) or (ii)) to the level of functional limitation described in clause (i) or (ii).

‘‘(D) CASH BENEFIT.—Payment of a cash benefit that satisfies the following require-
ments:

‘‘(i) MINIMUM REQUIRED AMOUNT.—The ben-
efit amount provides an eligible beneficiary with benefits that are less than an average of $50 per day-
ary (as determined based on the reasonably ex-
dected distribution of beneficiaries receiving benefits at various benefit levels).

‘‘(ii) NOT SUBJECT TO FUNDING ABIL-
ITY.—The benefit amount is varied based on a scale of functional ability, with not less than 2, and not more than 6, benefit level amounts.

‘‘(iii) DAILY OR WEEKLY.—The benefit is paid on a daily or weekly basis.

‘‘(iv) NO LIFETIME OR AGGREGATE LIMIT.—The benefit is not subject to any lifetime or aggregate limit.

‘‘(E) COORDINATION WITH SUPPLEMENTAL

COVERAGE OBTAINED THROUGH THE EX-
CHANGE.—An employer may allow for coverage with any supplemental coverage purchased through an Exchange established under sec-
ction 1311 of the Patient Protection and Af-
fordable Care Act.

‘‘(2) REVIEW AND RECOMMENDATION BY THE

CLASS INDEPENDENCE ADVISORY COUNCIL.—The CLASS Independence Advisory Council shall

‘‘(A) evaluate the alternative benefit plans developed under paragraph (1); and

‘‘(B) recommend for designation as the CLASS Independence Benefit Plan for offer-
ing to the public the plan that the Council determines best balances price and benefits to meet enrollees’ needs in an actuarially sound manner.

(3) DESIGNATION BY THE SECRETARY.—Not

later than October 1, 2012, the Secretary, taking into consideration the recommenda-
tion of the CLASS Independence Advisory Council under paragraph (2)(B), shall des-
ignate a benefit plan as the CLASS Inde-
pendence Benefit Plan. The Secretary shall publish such designation, along with details of the reasons for the selection by the Secretary, in a final rule that allows for a period of public comment.

(4) ADDITIONAL PREMIUM REQUIREMENTS.—

‘‘(1) ADJUSTMENT OF PREMIUMS.—

(A) IN GENERAL.—Except as provided in sub-
paragraphs (B), (C), (D), and (E), the amount of the monthly premium determined for an individual upon such individual’s en-
rollment in the CLASS program shall remain the same for as long as the individual is an active enrollee in the program.

(B) RECALCULATED PREMIUM IF REQUIRED FOR PAYMENT AFTER LAPSE.—

‘‘(i) IN GENERAL.—Subject to clause (ii), if the Secretary determines, based on the most recent report of the Board of Trustees of the CLASS Independence Fund, the advice of the CLASS Independence Advisory Council, and the annual report of the Inspector General of the Department of Health and Human Serv-
ces, and waste, fraud, and abuse, or such other information as the Secretary deter-
nines appropriate, that the monthly pre-
miums and income to the CLASS Inde-
pendence Fund are projected to be insufficient with respect to the 20-year period that begins with that year, the Secretary shall adjust the monthly premiums for indi-
viduals described in the CLASS program to:

‘‘(A) determine the monthly premium for enrollment in the CLASS program; or

‘‘(B) prevent an individual from enrolling in the program.

‘‘(c) SELF-ATTERTATION AND VERIFICATION

OF INCOME.—The Secretary shall establish procedures to—

‘‘(1) permit an individual who is eligible for the nominal premium required under sub-
section (a)(1)(A)(ii), or automatic enrollment in the CLASS program, to self-
testify that their income does not exceed the poverty line or that their status as a full-time student who is actively employed;

‘‘(2) verify, using procedures similar to the procedures used by the Commissioner of So-
cial Security under section 1631(e)(1)(B)(ii) of the Social Security Act, that the individual is consistent with the requirements applicable to the convey-
ance of data and information under section 1942 of such Act, the validity of such self-
attestation; and

‘‘(3) require an individual to confirm, on at

least an annual basis, that their income does not exceed the poverty line or that they con-
tinue to maintain such status.

SEC. 3204. ENROLLMENT AND DISENROLLMENT REQUIREMENTS.

‘‘(a) AUTOMATIC ENROLLMENT.—

‘‘(1) IN GENERAL.—Subject to paragraph (2), the Secretary, in coordination with the Sec-
retary of the Treasury, shall establish proce-
dures under which each individual described in subsection (c) may be
enrolled in the CLASS program by an employer of such individual in the same manner as an employer may elect to automatically enroll a participant in a plan under section 401(k), 403(b), or 457 of the Internal Revenue Code of 1986.

‘‘(b) ALTERNATIVE ENROLLMENT PROC-
dURES.—The procedures established under paragraph (1) shall provide for an alternative enrollment process for an individual described in subsection (c) in the case of such an individual—

‘‘(A) who is self-employed;

‘‘(B) who has more than 1 employer;

‘‘(C) whose employer does not elect to par-
ticipate in the automatic enrollment process established by the Secretary.

‘‘(2) ADMINISTRATION.—

‘‘(A) IN GENERAL.—The Secretary and the Secretary of the Treasury shall, by regula-
tion, establish procedures to ensure that an individual is not automatically enrolled in the CLASS program by more than 1 em-
ployer.

‘‘(B) FORM.—Enrollment in the CLASS pro-
gram shall be made in such manner as the Secretary may prescribe in order to ensure ease of administration.

‘‘(C) ELECTION TO OPT-OUT.—An individual described in subsection (c) may elect to waive enrollment in the CLASS program at any time in such form and manner as the Secretary and the Secretary of the Treasury shall prescribe.

‘‘(D) INDIVIDUAL DESCRIBED.—For purposes of enrolling in the CLASS program, an indi-
vidual described in this paragraph is an indi-

‘‘(1) who has attained age 18;

‘‘(2) who—

‘‘(A) receives wages on which there is im-
posed tax under section 1401(a) of the Inter-

nal Revenue Code of 1986;

‘‘(B) derives self-employment income on

which there is imposed a tax under section 1401(a) of the Internal Revenue Code of 1986;

‘‘(3) who is actively employed; and

‘‘(4) who is not—

‘‘(A) a patient in a hospital or nursing fa-

cility for a year or more;

‘‘(B) a child in care in an intermediate care facility for the mentally retarded, or an institution for men-
tal diseases and receiving medical assistance under Medicaid;

‘‘(C) an inmate in a jail, prison, other penal institution or correctional facility, or by court order pursuant to conviction of a
criminal offense or in connection with a verdict or finding described in section 202(x)(1)(A)(ii) of the Social Security Act (42 U.S.C. 423(x)(1)(A)(ii)).

(d) FEDERAL PAYMENT FOR PROCEDURE. — Nothing in this title shall be construed as requiring an active enrollee to continue to satisfy subsection (B) or (C) of subsection (c)(1) in order to maintain enrollment in the CLASS program.

(e) PAYMENT. — (1) PAYROLL DEDUCTION. — An amount equal to the monthly premium for the enrollment in the CLASS program of an individual shall be deducted from the wages or self-employment income of such individual in accordance with such procedures as the Secretary, in coordination with the Secretary of the Treasury, shall establish for employers who elect to deduct and withhold such premiums on behalf of enrolled employees.

(2) ALTERNATIVE PAYMENT MECHANISM. — The Secretary, in coordination with the Secretary of the Treasury, shall establish alternative procedures for the payment of monthly premiums by an individual enrolled in the CLASS program.

(2A) DETERMINATION OF ELIGIBILITY. — An active enrollee shall be deemed presumptively eligible if the enrollee—

(i) has applied for, and attests is eligible for, the maximum cash benefit available under the sliding scale established under the CLASS Independence Benefit Plan; and

(ii) enter into an agreement with the Secretary of the Treasury in accordance with subsection (d); and

(iii) enter into an agreement with local and public agencies and assisted living services, and an administrator of such services, to provide advocacy services in accordance with subsection (e).

(2B) REGULATIONS. — The Secretary shall promulgate regulations implementing this title, which regulations shall be accepted by the Social Security Act and the Medicare program for all purposes. The regulations shall include procedures for the enforcement of this title. The regulations shall establish procedures for obtaining assistance counseling in accordance with subsection (d), and a determination process, as certified by a licensed health care practitioner, an appeals process, and a reenrollment process, as certified by a licensed health care practitioner, including whether an active enrollee is eligible for a cash benefit under the program and if so, the amount of the cash benefit (in accordance with the sliding scale established under the plan).

(2C) PRESCRIPTIVE ELIGIBILITY FOR CERTAIN INSTITUTIONALIZED PLANNING TO DISCHARGE. — An active enrollee shall be deemed presumptively eligible if the enrollee—

(i) has applied for, and attests is eligible for, the sliding scale established under the CLASS Independence Benefit Plan.

(ii) is institutionalized (but only if the hospitalization is for long-term care), nursing facility, intermediate care facility for the mentally retarded, or an institution for mental diseases, and

(iii) is in the process of, or about to begin the process of, planning to discharge from the hospital, facility, or institution, or within 60 days from discharge from the hospital, facility, or institution.

(D) APPEALS. — The Secretary shall establish procedures under which an applicant for benefits under the CLASS Independence Benefit Plan shall be guaranteed the right to appeal an adverse determination.

(b) BENEFITS. — An eligible beneficiary shall receive benefits under the CLASS Independence Benefit Plan.

(1) Cash Benefit. — A cash benefit established by the Secretary in accordance with the requirements of section 3303(a)(1)(D) that—

(A) the first year in which beneficiaries receive the benefits under the plan, is not less than the amount specified in clause (i) of such section; and

(B) for any subsequent year, is not less than the average per day dollar limit applicable under such subparagraph for the preceding year, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) over the previous year.

(2) ADVOCACY SERVICES. — Advocacy services in accordance with subsection (d).

(3) ADVICE AND ASSISTANCE COUNSELING. — Advice and assistance counseling in accordance with subsection (e).

(4) ADMINISTRATIVE EXPENSES. — Advocacy services and advice and assistance counseling services under paragraphs (2) and (3) of this subsection shall be included as administrative expenses under section 3303(b)(3).

(c) PAYMENT OF BENEFITS. — (1) LIFE INDEPENDENCE ACCOUNT. —

(A) IN GENERAL. — The Secretary shall establish procedures for administering the provision of benefits to eligible beneficiaries under the CLASS Independence Benefit Plan, including the payment of the cash benefit for the beneficiary into a Life Independence Ac-
care services, habilitation services, and respite care under such a waiver or State plan amendment.

“(III) Definition of Home and Community-based Services.—The term ‘home and community-based services’ means any services which may be offered under a home and community-based waiver authorized under section 1115 of the Social Security Act (42 U.S.C. 1315) or sub-section (c) or (d) of section 1915 of such Act (42 U.S.C. 1396n) or under a State plan amendment under subsection (i) of such section.

“(III) Beneficiaries Enrolled in Programs of All-inclusive Care for the Elderly (PACE).—

“(1) In General.—Subject to clause (II), if a beneficiary is receiving medical assistance under Medicaid for PACE program services under section 1914 of the Social Security Act (42 U.S.C. 1396u-4), the beneficiary shall retain an amount equal to 50 percent of the beneficiary’s daily or weekly cash benefit (as applicable), and the remainder of the daily or weekly cash benefit shall be applied toward the cost to the State of providing such assistance (and not be used to claim Federal matching funds under Medicaid), and Medicare and any other secondary coverage for the remainder of any costs incurred in providing such assistance.

“(II) Determination of Benefits.—If a beneficiary receiving assistance under Medicaid for PACE program services is a patient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or an institution for mental diseases, the beneficiary shall be treated as in institutionalized beneficiary under clause (i).

“(2) Authorized Representatives.—

“(A) In General.—The Secretary shall establish procedures to allow access to a beneficiary’s cash benefits by an authorized representative of the eligible beneficiary on whose behalf such benefits are paid.

“(B) Quality Assurance and Protection Against Fraud and Abuse.—The procedures established under subparagraph (A) shall ensure that authorized representatives of eligible beneficiaries comply with standards of conduct established by the Secretary, including standards requiring that such representatives provide quality services on behalf of such beneficiaries, do not have conflicts of interest, and do not misuse benefits paid on behalf of such beneficiaries or otherwise engage in fraud or abuse.

“(3) Commencement of Benefits.—Benefits shall be paid on behalf of an eligible beneficiary beginning with the first month in which an application for such benefits is approved.

“(4) Employer Option for Lump-Sum Payment.—An eligible beneficiary may elect to—

“(A) defer payment of their daily or weekly cash benefit by rollover any such deferred benefits from month-to-month, but not from year-to-year; and

“(B) receive a lump-sum payment of such deferred benefits at any time in an amount that may not exceed the lesser of—

“(i) the total amount of the accrued deferred benefits; or

“(ii) 120 percent of the applicable annual benefit.

“(5) Period for Determination of Annual Benefits.—

“(A) In General.—The applicable period for determination of the amount which may be paid to an beneficiary the applicable annual benefit and the amount of any accrued deferred benefits is the 12-month period that commences with the month in which the beneficiary began to receive such benefits, and each 12-month period thereafter.

“(B) Inclusion of Increased Benefits.—The Secretary shall establish procedures under which cash benefits paid to an eligible beneficiary that increase or decrease as a result of a change in the functional status of the beneficiary before the end of a 12-month benefit period shall be included in the determination of the applicable annual benefit paid to the beneficiary.

“(C) Recoupment of Unpaid, Accrued Benefits.—

“(i) In General.—The Secretary, in coordination with the Secretary of the Treasury, shall recoup any accrued benefits in the event of—

“(I) the death of a beneficiary; or

“(II) the failure of a beneficiary to elect under paragraph (4)(B) to receive such benefits as a lump-sum payment before the end of the 12-month period in which such benefits accrued.

“(ii) Payment into Class Independence Fund.—Any benefits recouped in accordance with clause (i) shall be paid into the CLASS Independence Fund and used in accordance with section 3206.

“(D) Recertification of Eligibility.—An eligible beneficiary shall periodically, as determined by the Secretary—

“(A) recertify by submission of medical evidence the continued eligibility for receipt of benefits; and

“(B) submit records of expenditures attributable to the aggregate cash benefit received by the beneficiary in the preceding year.

“(E) Supplement, Not Supplant Other Health Care Benefits.—Subject to the Medicaid payment rules under paragraph (1)(D), benefits received by an eligible beneficiary shall supplement, but not supplant, other health care benefits for which the beneficiary is eligible under Medicaid or any other Federally funded program that provides health care benefits or assistance.

“(F) Advocacy Services.—An agreement entered into under subsection (a)(2)(A)(ii) shall require the Protection and Advocacy System for the State to—

“(i) assign, as needed, an advocacy counselor to each eligible beneficiary that is covered by such agreement and who shall provide an eligible beneficiary with—

“(I) information regarding how to access the appeals process established for the program;

“(II) assistance with respect to the annual recertification and notification required under subsection (c)(6); and

“(III) such other assistance with obtaining services as the Secretary, by regulation, shall require; and

“(2) ensure that the System and such counselors comply with the requirements of subsection (h).

“(G) Advice and Assistance Counseling.—An agreement entered into under subsection (a)(2)(A)(iii) shall require the entity to—

“(i) accessing and coordinating long-term services and supports in the most integrated setting;

“(ii) providing information to the active enrollee or beneficiary in a manner that fosters the best interests of the active enrollee or beneficiary.

“(2) Protections and Advocacy Services.—The entity serving as Managing Trustee of such Fund. The Fund shall consist of all amounts derived from payments into the Fund under sections 1115 and 1915 of the Social Security Act (42 U.S.C. 1315 et seq., 1396n) and section 3206 of this Act, and any other amounts deposited into the Fund by the Secretary of Veterans Affairs, under low-income housing assistance programs, or under the supplemental nutrition assistance program established under the Food and Nutrition Act of 2008 (7 U.S.C. 2011 et seq.).

“(G) Rule of Construction.—Nothing in this title shall be construed as prohibiting benefits paid under the CLASS Independence Benefit Plan from being used to compensate a family caregiver for providing community assistance services and supports to an eligible beneficiary.

“(h) Protection Against Conflict of Interests.—The Secretary shall establish procedures to ensure that the Protection and Advocacy System, the Protection and Advocacy System for a State, advocacy counselors for eligible beneficiaries, and any other entities that provide services to active enrollees and eligible beneficiaries under the CLASS program comply with the following:—

“(1) The entity providing counseling or planning services, such services are provided in a manner that fosters the best interests of the active enrollee or beneficiary.

“(2) The entity has established operating procedures that are designed to avoid or minimize conflicts of interest between the entity and an active enrollee or beneficiary.

“(3) The entity provides information about all services and options available to the active enrollee or beneficiary, to the best of its knowledge, including services available through other entities or providers.

“(4) The entity assists the active enrollee or beneficiary to access desired services, regardless of the provider.

“(5) The entity reports the number of active enrollees and beneficiaries provided with assistance by age, disability, and whether such enrollees and beneficiaries receive services from the entity or another entity.

“(6) If the entity provides counseling or planning services, the entity ensures that an active enrollee or beneficiary is informed of any financial interest that the entity has in a service provider.

“(h) Annual Report on Participation.—The entity providing counseling or planning services that can meet the needs of the active enrollee or beneficiary.

“SEC. 3206. CLASS INDEPENDENCE FUND.

“(a) Establishment of CLASS Independence Fund.—There is established in the Treasury of the United States a trust fund to be known as the ‘CLASS Independence Fund’. The Secretary shall serve as Managing Trustee of such Fund. The Fund shall consist of all amounts derived from payments into the Fund under sections 1115 and 1915 of the Social Security Act (42 U.S.C. 1315 et seq., 1396n) and section 3206 of this Act, and any other amounts deposited into the Fund by the Secretary of Veterans Affairs, under low-income housing assistance programs, or under the supplemental nutrition assistance program established under the Food and Nutrition Act of 2008 (7 U.S.C. 2011 et seq.).
of law which govern the way in which the Board of Trustees to do the following:

(i) Hold the CLASS Independence Fund.

(ii) Review the general policies followed in managing the CLASS Independence Fund, and recommend changes in such policies, in the opinion of the Board, whenever the Board is of the opinion that the Board is first issued under paragraph (2).

(iii) Report immediately to the Congress on the CLASS program. The report shall include provisions to prevent fraud and abuse under the program.

(iv) An actuarial opinion by the Chief Actuary of the Centers for Medicare & Medicaid Service.

(b) LIMITATION.—A member shall not be appointed to the CLASS Independence Advisory Council unless the member shall serve in such position after the expiration of the member's term until the earlier of the time at which the member's successor takes office or the time at which a report of the Board is first issued under paragraph (2) after the expiration of the member's term.

(b) No taxpayer funds used to pay benefits.—No taxpayer funds shall be used for payment of benefits of the CLASS Independence Benefit Plan. For purposes of this subsection, the term ‘taxpayer funds’ means any Federal funds from a source other than program participant contributions, including deposits by program participants in the CLASS Independence Fund and any associated interest earnings.

(c) Regulations.—The Secretary shall promulgate such regulations as are necessary to carry out the CLASS program in accordance with this title. Such regulations shall include provisions to prevent fraud and abuse under the program.

(d) Annual report.—Beginning January 1, 2014, the Secretary shall submit an annual report to Congress on the CLASS program. Each report shall include the following:

(1) The total number of enrollees in the program.

(2) The total number of eligible beneficiaries.

(3) The total amount of cash benefits provided during the fiscal year.

(4) A description of instances of fraud or abuse identified during the previous fiscal year.

(5) Recommendations for such administrative or legislative action as the Secretary determines is necessary to improve the program, ensure the solvency of the program, or prevent the occurrence of fraud or abuse.

(e) Authorization of appropriations.—

(1) In general.—There are authorized to the Secretary of the Treasury to carry out its duties under this section, such sums as may be necessary for fiscal year 2011 and for each fiscal year thereafter.

(2) Availability.—Any sums appropriated under the authorization contained in this section shall remain available, without fiscal year limitation, until expended.

(3) To pay cash benefits to eligible beneficiaries under the CLASS Independence Benefit Plan.

(4) To pay cash benefits to eligible beneficiaries under the CLASS Independence Benefit Plan.

(5) To pay cash benefits to eligible beneficiaries under the CLASS Independence Benefit Plan.

(6) To pay cash benefits to eligible beneficiaries under the CLASS Independence Benefit Plan.

(f) Authorization of appropriations.—

(1) In general.—There are authorized to the Secretary of the Treasury to carry out its duties under this section, such sums as may be necessary for fiscal year 2011 and for each fiscal year thereafter.

(2) Availability.—Any sums appropriated under the authorization contained in this section shall remain available, without fiscal year limitation, until expended.

SEC. 3208. SOLVENCY AND FISCAL INDEPENDENCE; REGULATIONS; ANNUAL REPORT.

(a) Solvency.—The Secretary shall regularly consult with the Board of Trustees of the CLASS Independence Fund and the CLASS Independence Advisory Council, for purposes of ensuring that enrollees' premiums are adequate to ensure the financial solvency of the CLASS program, both with respect to fiscal years occurring in the near-term and fiscal years occurring over 5- and 7-year periods, taking into account the projections required for such periods under subsections (a)(1)(A)(i) and (b)(1)(B)(i) of section 3202.

(b) No taxpayer funds used to pay benefits.—No taxpayer funds shall be used for payment of benefits of the CLASS Independence Benefit Plan. For purposes of this subsection, the term ‘taxpayer funds’ means any Federal funds from a source other than program participant contributions, including deposits by program participants in the CLASS Independence Fund and any associated interest earnings.

(c) Regulations.—The Secretary shall promulgate such regulations as are necessary to carry out the CLASS program in accordance with this title. Such regulations shall include provisions to prevent fraud and abuse under the program.

(d) Annual report.—Beginning January 1, 2014, the Secretary shall submit an annual report to Congress on the CLASS program. Each report shall include the following:

(1) The total number of enrollees in the program.

(2) The total number of eligible beneficiaries.

(3) The total amount of cash benefits provided during the fiscal year.

(4) A description of instances of fraud or abuse identified during the previous fiscal year.

(5) Recommendations for such administrative or legislative action as the Secretary determines is necessary to improve the program, ensure the solvency of the program, or prevent the occurrence of fraud or abuse.

SEC. 3209. INSPECTOR GENERAL’S REPORT.

The Inspector General of the Department of Health and Human Services shall submit an annual report to the Secretary and Congress relating to the overall progress of the CLASS program and of the existence of waste, fraud, and abuse in the CLASS program. Each such report shall include findings in the following areas:

(1) The eligibility determination process.

(2) Provision of financial benefits.

(3) Quality assurance and protection against waste, fraud, and abuse.

(4) Recovery of unpaid and accrued benefits.

SEC. 3210. TAX TREATMENT OF PROGRAM.

The CLASS program shall be treated for purposes of the Internal Revenue Code of 1986 in the same manner as a qualified long-term care insurance contract for qualified long-term care services.”.

(2) Conforming amendments to medicaid.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended by adding section 6605, as added by section 6605, is amended by inserting after paragraph (80) the following:
“(8) provide that the State will comply with such regulations regarding the application of primary and secondary payor rules with respect to individuals who are eligible for medical assistance under this title, and are eligible beneficiaries under the CLASS program established under title XXII of the Public Health Service Act as the Secretary shall establish; and

(b) Assurance of Adequate Infrastructure for the Provision of Personal Care Attendants and Home Health Workers.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a), as amended by subsection (a)(2), is amended by inserting after paragraph (8) the following:—

“(8) provide that—

(1) not later than 2 years after the date of enactment of the Community Living Assistance Services and Supports Act, each State shall—

(A) certify in writing to the extent that entities such as providers of home care, home health services, home and community service providers, public authorities created to provide personal care services to individuals eligible for medical assistance under the State plan, and nonprofit organizations, are serving or have the capacity to serve as fiscal agents for, employers of, and providers of employment-related benefits for, personal care attendant workers who provide personal care services to individuals receiving benefits under the CLASS program established under title XXII of the Public Health Service Act, including in rural and underserved areas;

(B) create such entities to serve as fiscal agents for, employers of, and providers of employment-related benefits for, such workers to ensure an adequate supply of the workers for individuals receiving benefits under the CLASS program, including in rural and underserved areas; and

(C) ensure that the designation or creation of such entities will not negatively alter or impede existing programs, models, methods, or administration of service delivery that provide for consumer controlled or self-directed home and community services, including the ability to select, manage, direct, co-employ, or employ such workers or inhibit such individuals from relying on family members for the provision of personal care services;

(c) Personal Care Attendants Workforce Advisory Panel.—

(1) Establishment.—Not later than 90 days after the date of enactment of this Act, the Secretary of Health and Human Services shall establish a Personal Care Attendants Workforce Advisory Panel for the purpose of examining and advising the Secretary and Congress on workforce issues related to personal care attendant workers, including with respect to the adequacy of the number of such workers, their qualifications, wages, and benefits of such workers, and access to the services provided by such workers.

(2) Membership.—In appointing members to the Personal Care Attendants Workforce Advisory Panel, the Secretary shall ensure that such members include the following:

(A) Individuals with disabilities of all ages.

(B) Representatives of individuals with disabilities.

(C) Representatives of senior individuals.

(D) Representatives of worker organizations.

(E) Representatives of home and community-based service providers.

(F) Representatives of assisted living providers.

(d) Inclusion of Information on Supplemental Medical Assistance Program.—Section 602(d) of the Deficit Reduction Act of 2005 (42 U.S.C. 1396p note) is amended—

(1) in paragraph (2)(A)—

(A) by striking “(ii) by striking “and” at the end;

(B) in clause (iii), by striking the period at the end and inserting “; and”;

and (C) by adding at the end the following:

“(I) the dollar amount in clause (i)(I) (determined after the application of subparagraph (D)) shall be increased by $1,350, and

(II) the dollar amount in clause (i)(II) (determined after the application of subparagraph (D)) shall be increased by $3,000.

(2) Subsequent Years.—In the case of any calendar year after 2013, each of the dollar amounts under clauses (i) and (ii) shall be increased to the amount equal to such amount as in effect for the calendar year preceding such year, increased by an amount equal to the product of—

(I) such amount as in effect, multiplied by

(II) the cost-of-living adjustment determined under section 11(f)(3) for such year (determined after substituting the calendar year that is 2 years before such year for ’1992’ in subparagraph (B) thereof), increased by 1 percentage point.

If any amount determined under this clause is not a multiple of $50, such amount shall be rounded to the nearest multiple of $50.

(2) Transition for States with Highest Coverage Costs.—

(1) In General.—If an employee is a resident of a high cost State on the first day of any month beginning in 2013, 2014, or 2015, the annual limitation under this paragraph for such month with respect to such employee shall be an amount equal to the applicable percentage of the annual limitation determined without regard to this subparagraph (B)(ii)).

(2) Applicable Percentage.—The applicable percentage is 120 percent for 2013, 110 percent for 2014, and 105 percent for 2015.

(3) High Cost State.—The term ‘high cost State’ means each of the 17 States which the Secretary of Health and Human Services, in consultation with the Secretary, estimates had the highest average cost dur- ing 2012 for employersponsored health coverage under health plans. The Secretary’s estimate shall be made on the basis of aggregate premiums paid in the State for such health plans, using the most recent data available as of August 31, 2012.

(3) Liability to Pay Tax.—

(1) In General.—Each coverage provider shall pay the tax imposed by subsection (a) on its applicable share of the excess benefit with respect to an employee for any taxable period.

(2) Coverage Provider.—For purposes of this subsection, the term ‘coverage provider’ means each of the following:

(A) Health Insurance Coverage.—If the applicable employer-sponsored coverage consists of coverage under a group health plan which provides health insurance coverage, the health plan administrator.

(B) HSA and MSA Contributions.—If the applicable employer-sponsored coverage consists of coverage under an arrangement under which the employer makes contributions described in subsection (b) or (d) of section 106, the employer.

(C) Other Coverage.—In the case of any other applicable employer-sponsored coverage, the person that administers the plan.

(4) Applicable Share.—For purposes of this subsection, a coverage provider’s applicable share of an excess benefit for any taxable period is the amount which bears the
which provides coverage to retired employees, the plan may elect to treat a retired employee who has not attained the age of 65 and a retired employee who has attained the age of 65 as similarly situated beneficiaries.

(B) HEALTH INSURANCE.—In the case of applicable employer-sponsored coverage consisting of coverage under a flexible spending arrangement (within the meaning of section 105 of the Internal Revenue Code of 1986), the cost of the coverage shall be equal to the sum of—

(i) the amount of employer contributions with respect to the total excess benefit under the arrangement, plus

(ii) the amount determined under subparagraph (A) with respect to any reimbursements under the arrangement (in excess of the contributions described in clause (i)).

(C) ARCHER MSA AND HSA.—In the case of applicable employer-sponsored coverage consisting of coverage under an arrangement under which the employer makes contributions described in subsection (b) or (d) of section 106, the cost of the coverage shall be equal to the amount of employer contributions under the arrangement.

(D) ALLOCATION ON A MONTHLY BASIS.—If cost is determined on a monthly basis, the cost determined as provided in the case of an employer which is excludable from the employee's gross income under section 106, or would be so excludable if it were employed-employer-provided coverage (within the meaning of section 106), shall be allocated to each month in accordance with the number of days in the month for which such cost would have been allocable to the employee.

(E) GOVERNMENTAL PLANS INCLUDED.—Applicable employer-sponsored coverage shall include coverage under any group health plan made available to eligible employees of any governmental plan, not withstanding section 7707 of the Internal Revenue Code of 1986.

(2) LIMITATIONS ON PENALTY.—

(A) PENALTY NOT TO APPLY WHERE FAILURE TO PREPARE TAX RETURN IS DUE TO REASONABLE INQUIRY.—If, for any taxable period, the employer or plan sponsor neither knew, nor exercising reasonable diligence, that such failure was due to reasonable cause and not to willful neglect, the Secretary may have different aggregation rules (as defined in section 5000A(f)(2)) to the extent provided by the Secretary in regulations.

(B) ACTION TO ENFORCE.—In the case of employer sponsored coverage, the employer or plan sponsor shall, in accordance with subparagraph (A), calculate the excess benefit during any period of not less than 20 years during the taxable period for employers of differing sizes.

(C) Archer MSA and HSA.—In the case of applicable employer-sponsored coverage consisting of coverage under an arrangement under which the employer makes contributions described in subsection (b) or (d) of section 106, the cost of the coverage shall be equal to the amount of employer contributions under the arrangement.

(D) ALLOCATION ON A MONTHLY BASIS.—If cost is determined on a monthly basis, the cost determined as provided in the case of an employer which is excludable from the employee's gross income under section 106, or would be so excludable if it were employed-employer-provided coverage (within the meaning of section 106), shall be allocated to each month in accordance with the number of days in the month for which such cost would have been allocable to the employee.

(E) GOVERNMENTAL PLANS INCLUDED.—Applicable employer-sponsored coverage shall include coverage under any group health plan made available to eligible employees of any governmental plan, not withstanding section 7707 of the Internal Revenue Code of 1986.
amended by section 1513, is amended by adding at the end the following new item:

“(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2012.

SEC. 9002. INCLUSION OF COST OF EMPLOYER-SUPPORTED HEALTH COVERAGE ON W-2.

(a) In General.—Section 6051(a) of the Internal Revenue Code of 1986 is amended—

(1) by redesignating paragraphs (1) and (2) as subsections (j) and (k), respectively, and

(2) by inserting after subsection (h) the following new paragraph:

“(1) the aggregate cost of prescription drugs prescribed by a physician, surgeon, or other licensed medical practitioner for an individual who is a member of the employee’s family, and

“(2) the aggregate cost of other medical services or supplies provided by a physician, surgeon, or other licensed medical practitioner for an individual who is a member of the employee’s family.”.

(b) Effective Date.—The amendments made by this section shall apply to taxable years beginning after December 31, 2012.

SEC. 9003. DISTRIBUTIONS FOR MEDICINE QUALIFIED ONLY IF FOR PRESCRIBED DRUG OR INSULIN.

(a) $500 Credit.—Subsection (a) of section 223(d)(2) of the Internal Revenue Code of 1986 is amended by striking “five percent” and inserting “five percent”.

(b) Effective Date.—The amendments made by this section shall apply to taxable years beginning after December 31, 2010.

SEC. 9004. CONDITIONS FOR MEDICINE QUALIFIED ONLY IF FOR PRESCRIBED DRUG OR INSULIN.

(a) In General.—Section 6014 of the Internal Revenue Code of 1986 is amended—

(1) by redesignating subsections (c), (d), (e), (f), (g), (h), and (i) as subsections (c), (d), (e), (f), (g), (h), and (i), respectively, and

(2) by striking paragraphs (2) and (3) of subsection (g).

(b) Effective Date.—The amendments made by this section shall apply to taxable years beginning after December 31, 2010.

(c) $500 Credit.—Subsection (a) of section 223(d)(2) of the Internal Revenue Code of 1986 is amended by inserting “five percent” in place of “five percent”.

(d) Effective Date.—The amendments made by this section shall apply to taxable years beginning after December 31, 2010.

SEC. 9005. LIMITATION ON HEALTH FLEXIBLE SPENDING ARRANGEMENTS UNDER CAREER RETIREMENT PROGRAMS.

(a) In General.—Section 106 of the Internal Revenue Code of 1986 is amended—

(1) by redesignating subsections (i) and (j) as subsections (k) and (l), respectively, and

(2) by inserting after subsection (h) the following new subsection:

“(i) LIMITATION ON HEALTH FLEXIBLE SPENDING ARRANGEMENTS.—Except as provided in subsection (k), no benefit shall be treated as a qualified benefit unless the cafeteria plan provides that an employee may choose to have any taxable year to have salary reduction contributions in excess of $2,500 made to such arrangement.

(b) Effective Date.—The amendments made by this section shall apply to taxable years beginning after December 31, 2012.

SEC. 9006. EXPANSION OF INFORMATION REPORTING REQUIREMENTS.

(a) In General.—Section 6041 of the Internal Revenue Code of 1986 is amended—

(1) by redesignating subsections (a), (b), and (c) as subsections (i), (j), and (k), respectively, and

(2) by striking out in their entirety paragraphs (1), (2), and (3) of subsection (a).

(b) Effective Date.—The amendments made by this section shall apply to taxable years beginning after December 31, 2010.

SEC. 9007. ADDITIONAL REQUIREMENTS FOR CHARITABLE HOSPITALS.

(a) Requirements for 501(c)(3) Charitable Hospital Organizations.—Section 501 of the Internal Revenue Code of 1986 is amended—

(1) by inserting “assets in consideration for property,” after “wages,”

(2) by inserting “and such arrangements are to be carried on in a manner which is consistent with the purposes described in subsection (c)(3) of section 113 of the Code for the provision of medical care,” after “property, or services,”

(3) by redesignating subsection (d) as subsection (e), inserting “and”, and inserting the following new subsection:

“(c) For Hospitals.—For purposes of this subsection—

(i) In General.—A hospital organization (within the meaning of section 113 of the Code) shall not be treated as described in subsection (c)(3) unless—

(A) it provides medical care for individuals who are recipients of public assistance and is operated for the purpose of providing care for individuals who are recipients of public assistance, and

(B) it meets the requirements described in paragraph (4)(C).

(ii) Exclusions.—The term ‘hospital organization’ does not include—

(A) any organization that is prohibited by State law from providing care to individuals who are recipients of public assistance,

(B) any organization that is operated for the purpose of providing care other than medical care for individuals who are recipients of public assistance,

(C) any organization that is primarily engaged in providing care for individuals who are recipients of public assistance in connection with services provided through Medicare or Medicaid,

(D) any organization that is not operated for an exempt purpose described in section 501(c)(3) of the Code.

(iii) Exclusions.—The term ‘hospital organization’ does not include—

(A) any organization that is primarily engaged in providing care for individuals who are recipients of public assistance in connection with services provided through Medicare or Medicaid,

(B) any organization that is not operated for an exempt purpose described in section 501(c)(3) of the Code.

(iv) Exclusions.—The term ‘hospital organization’ does not include—

(A) any organization that is primarily engaged in providing care for individuals who are recipients of public assistance in connection with services provided through Medicare or Medicaid,

(B) any organization that is not operated for an exempt purpose described in section 501(c)(3) of the Code.

(b) Effective Date.—The amendments made by this section shall apply to taxable years beginning after December 31, 2010.

SEC. 9008. LIMITATION ON CHARGES.—An organization that is not described in section 501(c)(3) of the Code shall not be treated as described in section 170(b)(1)(A)(iv) unless—

(a) In General.—This subsection shall apply to—

(i) an organization which operates a facility which is required by a State to be licensed, registered, or similarly recognized as a hospital, and

(ii) any other organization which the Secretary determines has the provision of hospital care as its principal function or purpose constituting the basis for its exemption under subsection (c)(1) (determined without regard to this subsection).

(b) Organizations with More than 1 Hospital Facility.—If a hospital organization operates more than one hospital facility—

(i) the organization shall meet the requirements of this subsection separately with respect to each such facility, and

(ii) the organization shall not be treated as described in subsection (c)(3) with respect to any such facility for which such requirements are not separately met.

(c) Community Health Needs Assessments.—

(a) In General.—An organization meets the requirements of this paragraph with respect to any taxable year only if the organization—

(i) takes into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge or expertise in public health, and

(ii) is made widely available to the public.

(b) Financial Assistance Policy.—An organization meets the requirements of this paragraph if the organization establishes the following policies:

(i) Eligibility criteria for financial assistance, and whether such assistance includes free or discounted care,

(ii) the basis for calculating amounts charged to patients,

(iii) a method for applying for financial assistance,

(iv) the in the case of an organization which does not have a separate billing and collection policy, the actions the organization may take in the event of non-payment, including collections action and reporting to credit agencies, and

(iv) measures to widely publicize the policy within the community to be served by the organization.

(c) Policy Relating to Emergency Medical Care.—A hospital organization may not provide the organization to provide, without discrimination, care for emergency medical conditions (within the meaning of section 1867 of the Social Security Act (42 U.S.C. 1395l)) to individuals regardless of their eligibility under the financial assistance policy described in paragraph (A).

(d) Limitation on Charges.—An organization meets the requirements of this paragraph if the organization—

(i) limits amounts charged for emergency medical care to individuals who have insurance covering such care, and

(ii) prohibits the use of gross charges.
(6) BILLING AND COLLECTION REQUIREMENTS.—An organization meets the requirement of this paragraph only if the organization does not engage in extraordinary collection actions. The organization having made reasonable efforts to determine whether the individual is eligible for assistance under the financial assistance policy described in paragraph (4)(A).

(7) REGULATORY AUTHORITY.—The Secretary shall issue such regulations and guidance as may be necessary to carry out the provisions of this subsection, including guidance relating to what constitutes reasonable efforts to determine the eligibility of a patient under a financial assistance policy for purposes of paragraph (6).

(b) EXCISE TAX FOR FAILURES TO MEET HOSPITAL EXEMPTION REQUIREMENTS.—

(1) IN GENERAL.—Subchapter D of chapter 42 of the Internal Revenue Code of 1986 (relating to failure to meet certain qualification requirements) is amended by adding at the end of the following new section:

"SEC. 4959. TAXES ON FAILURES TO MEET HOSPITAL EXEMPTION REQUIREMENTS.

"If a hospital organization to which section 501(r) applies fails to meet the requirement of section 501(r)(3) for any taxable year, there is imposed on the organization a tax equal to 50 percent.

(2) CONFORMING AMENDMENT.—The title of sections for subchapter D of chapter 42 of such Code is amended by adding at the end the following new number:

"Sec. 4959. Taxes on failures by hospital organizations."

(c) MANDATORY REVIEW OF TAX EXEMPTION FOR HOSPITALS.—The Secretary of the Treasury or the Secretary’s delegate shall review at least once every 3 years the community benefit activities of each hospital organization to which section 501(r) of the Internal Revenue Code of 1986 (as added by this section) applies.

(d) ADDITIONAL REPORTING REQUIREMENTS.—

(1) COMMUNITY HEALTH NEEDS ASSESSMENTS AND AUDITED COMBINED FINANCIAL STATEMENTS.—Section 5033(b) of the Internal Revenue Code of 1986 (relating to certain organizations described in section 501(c)(3)) is amended by striking paragraph (15) and by redesigning paragraph (15) as paragraph (16), and by inserting after paragraph (14) the following new paragraph:

With respect to a covered entity’s aggregate branded prescription drug sales during the calendar year that are:

<table>
<thead>
<tr>
<th>Sales Range</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>More than $5,000,000</td>
<td>0 percent</td>
</tr>
<tr>
<td>More than $5,000,000 but not more than $125,000,000</td>
<td>10 percent</td>
</tr>
<tr>
<td>More than $125,000,000 but not more than $225,000,000</td>
<td>75 percent</td>
</tr>
<tr>
<td>More than $225,000,000 but not more than $400,000,000</td>
<td>100 percent</td>
</tr>
</tbody>
</table>

(3) SECRETARIAL DETERMINATION.—The Secretary of the Treasury shall calculate the amount of each covered entity’s fee for any calendar year under paragraph (1). In calculating such amount, the Secretary of the Treasury shall determine such covered entity’s brand-name drug sales by the basis of reports submitted under subsection (g) and through the use of any other source of information available to the Secretary of the Treasury.

(c) TRANSFER OF FEES TO MEDICARE PART B TRUST FUND.—There is hereby appropriated to the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of the Social Security Act an amount equal to the fees received by the Secretary of the Treasury under this section.

(d) COVERED ENTITY.—

(1) IN GENERAL.—For purposes of this section, the term “covered entity” means any manufacturer or importer with gross receipts from sales of branded prescription drug sales.

(2) CONTROLLED GROUPS.—

(1) IN GENERAL.—For purposes of this subsection, all persons treated as a single organization under section 414 of such Code are included in a consolidated financial statement with other organizations, such consolidated financial statement.

(2) I NCLUSION OF FOREIGN CORPORATIONS.—Section 501(f) of such Code is amended by striking “and” at the end of subparagraph (B), by inserting “and” at the end of subparagraph (C), and by adding at the end the following new subparagraph:

"(D) section 4959 (relating to taxes on failures by hospital organizations)."

(e) REPORTS.—

(1) REPORT ON LEVELS OF CHARITY CARE.—The Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, shall submit to the Committees on Finance and Health, Education, Labor, and Pensions of the Senate an annual report on the following:

(A) Information with respect to private tax-exempt, taxable, and government-owned hospitals regarding

(i) levels of charity care provided,

(ii) bad debt expenses,

(iii) unreimbursed costs for services provided with respect to means-tested government programs, and

(iv) reimbursements for services provided consistent with respect to non-means-tested government programs.

(B) Information with respect to private tax-exempt hospitals regarding costs incurred for community benefit activities.

(2) REPORT ON TRENDS.—

(A) STUDY.—The Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, shall conduct a study on trends in the information required to be reported under paragraph (1).

(B) REPORT.—Not later than 5 years after the date of the enactment of this Act, the Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, shall submit a report on the study conducted under subparagraph (A) to the Committees on Ways and Means, Education and Labor, and Energy and Commerce of the House of Representatives and to the Committees on Finance and Health, Education, Labor, and Pensions of the Senate.

(f) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in paragraphs (2) and (3), the amendments made by this section shall apply to taxable years beginning after the date of the enactment of this Act.

(2) COMMUNITY HEALTH NEEDS ASSESSMENT.—The requirements of section 501(r)(3) of the Internal Revenue Code of 1986, as added by subsection (a), shall apply to taxable years beginning after the date which is 2 years after the date of the enactment of this Act.

(3) EXCISE TAX.—The amendments made by subsection (b) shall apply to failures occurring after the date of the enactment of this Act.

SEC. 9008. IMPOSITION OF ANNUAL FEE ON BRANDED PRESCRIPTION PHARMACEUTICAL MANUFACTURERS AND IMPORTERS.

(a) IMPOSITION OF FEE.—

(1) IN GENERAL.—Each covered entity engaged in the business of manufacturing or importing branded prescription drugs shall be subject to an annual payment beginning the date which is 2 years after the date of the enactment of this Act.

(2) ANNUAL PAYMENT DUE.—For purposes of this section, the term “annual payment due” means with respect to any calendar year the date determined by the Secretary, but in no event later than September 30 of such calendar year.

(b) DETERMINATION OF FEE AMOUNT.—

(1) IN GENERAL.—With respect to each covered entity, the fee under this section for any calendar year shall be equal to an amount that bears the same ratio to $2,300,000,000 as:

(A) the covered entity’s branded prescription drug sales taken into account during the preceding calendar year, bear to

(B) the aggregate branded prescription drug sales of all covered entities taken into account during such preceding calendar year.

(2) SALES TAKEN INTO ACCOUNT.—For purposes of paragraph (1), the branded prescription drug sales of a covered entity for any calendar year with respect to any covered entity shall be determined in accordance with the following table:

The percentage of such sales taken into account is:

<table>
<thead>
<tr>
<th>Percent</th>
<th>Sales Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>More than $5,000,000</td>
</tr>
<tr>
<td>10</td>
<td>More than $5,000,000 but not more than $125,000,000</td>
</tr>
<tr>
<td>75</td>
<td>More than $225,000,000 but not more than $400,000,000</td>
</tr>
<tr>
<td>100</td>
<td>More than $400,000,000</td>
</tr>
</tbody>
</table>

(3) SECRETARIAL DETERMINATION.—The Secretary of the Treasury shall determine the amount of the annual fee for any calendar year under paragraph (1). In calculating such amount, the Secretary of the Treasury shall determine such covered entity’s branded prescription drug sales by the basis of reports submitted under subsection (g) and through the use of any other source of information available to the Secretary of the Treasury.

(c) TRANSFER OF FEES TO MEDICARE PART B TRUST FUND.—There is hereby appropriated to the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of the Social Security Act an amount equal to the fees received by the Secretary of the Treasury under this section.

(d) COVERED ENTITY.—

(1) IN GENERAL.—For purposes of this section, the term “covered entity” means any manufacturer or importer with gross receipts from sales of branded prescription drug sales.

(2) CONTROLLED GROUPS.—

(1) IN GENERAL.—For purposes of this subsection, all persons treated as a single employer under section 414 of such Code shall be treated as a single covered entity.

(B) INCLUSION OF FOREIGN CORPORATIONS.—For purposes of subparagraph (A), in applying subsections (a) and (b) of section 52 of such Code shall be applied without regard to subset (b)(2)(C)(i) thereof.

(e) BRANDED PRESCRIPTION DRUG SALES.—

For purposes of this section:

(1) IN GENERAL.—The term “branded prescription drug sales” means—

(A) the term “branded prescription drug sales” means—

(i) any prescription drug the application for which was submitted under section 505(b)
(1) MEDICARE PART D PROGRAM.—The Secretary of Health and Human Services shall report, for each covered entity and for each branded prescription drug of the covered entity covered by the Medicare Part D program, the product of—
(A) the per-unit ingredient cost, as reported to the Secretary of Health and Human Services, minus any per-unit rebate, discount, or other price concession provided by the covered entity; and
(B) for each such branded prescription drug, the product of—
(i) the per-unit ingredient cost, minus any per-unit rebate paid by the covered entity; and
(ii) the number of units of the branded prescription drug dispensed under such program.

(C) SECRETARIAL DETERMINATION.—The Secretary shall calculate the amount of each covered entity’s fee for any calendar year under paragraph (1), in calculating such amount the Secretary shall determine such covered entity’s gross receipts from medical device sales on the basis of reports submitted by the covered entity under subsection (f) and through the use of any other source of information available to the Secretary.

(2) MEDICARE PART B PROGRAM.—The Secretary of Health and Human Services shall report, for each covered entity and for each branded prescription drug of the covered entity covered by the Medicare Part B program, the product of—
(A) the per-unit ingredient cost, as defined in section 1847A(c) of the Social Security Act or the per-unit Part B payment rate for a non-preference drug or a preference drug without a reported average sales price, and
(B) the number of units of the branded prescription drug paid for under the Medicare Part B program.

(3) SECRETARIAL DETERMINATION.—The Secretary shall determine the amount of each covered entity’s fee for any calendar year under paragraph (2)(A), in calculating such amount the Secretary shall determine such covered entity’s gross receipts from medical device sales on the basis of reports submitted by the covered entity under subsection (f) and through the use of any other source of information available to the Secretary.

(4) EXCLUSION OF ORPHAN DRUG SALES.—The term “branded prescription drug” means any drug which is subject to section 503(b) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 353(b)).

(5) DEPARTMENT OF DEFENSE PROGRAMS AND TRICARE.—Drug administration for marketing for any rare disease or condition with respect to which such credit was allowed.

(6) APPLICABILITY.—Nothing in this section shall be construed to apply with respect to any drug or biological product after the date on which such drug or biological product is approved by the Food and Drug Administration for marketing for any indication other than the treatment of the rare disease or condition with respect to which such credit was allowed.

(7) SPECIFIED GOVERNMENT PROGRAM.—The term “specified government program” means—
(A) the Medicare Part D program under part D of title XVIII of the Social Security Act;
(B) the Medicare Part B program under part B of title XVIII of the Social Security Act;
(C) the Medicaid program under title XIX of the Social Security Act;
(D) any program under which branded prescription drugs are procured by the Department of Veterans Affairs;
(E) any program under which branded prescription drugs are procured by the Department of Defense; or
(F) the TRICARE retail pharmacy program under section 1074g of title 10, United States Code.

(8) TAX TREATMENT OF FEE.—The fees imposed by this section—
(1) for purposes of subtitle F of the Internal Revenue Code of 1986, shall be treated as excise taxes with respect to which only civil actions for refund under procedures of such subtitle shall apply, and
(2) for purposes of section 275 of such Code, shall be considered to be a tax described in section 52 of such Code.

(9) REPORTING REQUIREMENT.—Not later than the date determined by the Secretary of the Treasury following the end of any calendar year, the Secretary of Health and Human Services, the Secretary of Veterans Affairs, and the Secretary of Defense shall report to the Secretary of the Treasury, in such manner as the Secretary of the Treasury prescribes, the total branded prescription drug sales for each covered entity, with respect to each specified government program under such Secretary’s jurisdiction using the following methodology:

With respect to a covered entity’s aggregate gross receipts from medical device sales during the calendar year that are:

<table>
<thead>
<tr>
<th>Gross Receipts</th>
<th>Percentage of Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not more than $5,000,000</td>
<td>0 percent</td>
</tr>
<tr>
<td>More than $5,000,000 but not more than $25,000,000</td>
<td>50 percent</td>
</tr>
<tr>
<td>More than $25,000,000</td>
<td>100 percent</td>
</tr>
</tbody>
</table>

(10) IN GENERAL.—For purposes of this section, the term “covered entity” means any manufacturer or importer with gross receipts from medical device sales.
section 275(a)(6). shall be considered to be a tax described in subtitle shall apply, and excise taxes with respect to which only civil nal Revenue Code of 1986, shall be treated as imposed by this section— proposed by this section for which such report was required. (B) TREATMENT OF PENALTY. The penalty imposed under subparagraph (A)— (i) shall be treated as a penalty for purposes of subtitle F of the Internal Revenue Code of 1986; (ii) shall be paid on notice and demand by the Secretary and in the same manner as tax under such Code, and (iii) with respect to which only civil actions for refund under procedures of such subtitle S shall apply. (g) SECRETARY. For purposes of this section, the term “Secretary” means the Secretary of the Treasury or the Secretary’s delegate. (b) GUIDANCE. The Secretary shall publish guidance necessary to carry out the purposes of this section, including identification of medical devices described in subsection (d)(1)(A) and with respect to the treatment of gross receipts from sales of medical devices to another covered entity or to another entity by reason of the application of subsection (c)(2). (i) APPLICATION OF SECTION. This section shall apply to any medical device sales after December 31, 2008.

With respect to a covered entity’s net premiums written during the calendar year that are:

Not more than $25,000,000 ............................................................................. 0 percent
More than $25,000,000 but not more than $50,000,000 ........................................ 50 percent
More than $50,000,000 ............................................................................. 100 percent.

(b) THIRD PARTY ADMINISTRATION AGREEMENT FEES. The third party administration agreement fees that are taken into account during any calendar year with respect to any covered entity shall be determined in accordance with the following table:

With respect to a covered entity’s third party administration agreement fees during the calendar year that are:

Not more than $5,000,000 ............................................................................. 0 percent
More than $5,000,000 but not more than $10,000,000 ........................................ 50 percent
More than $10,000,000 ............................................................................. 100 percent.

(3) SECRETARIAL DETERMINATION. The Secretary shall calculate the amount of each covered entity’s fee for any calendar year under paragraph (1). In calculating such amount, the Secretary shall determine such covered entity’s net premiums written with respect to any United States health risk and third party administration agreement fees on the basis of reports submitted by the covered entity under subsection (g) and through the use of any other source of information available to the Secretary. (c) COVERED ENTITY. (1) GENERAL. For purposes of this section, the term “covered entity” means any entity which provides health insurance for any United States health risk. (2) EXCLUSION. Such term does not include

(A) any employer to the extent that such employer self-insures its employees’ health risks, or
(B) any governmental entity (except to the extent such an entity provides health insurance coverage through the community health insurance option under section 1323).

(3) CONTROLLED GROUPS. (A) IN GENERAL. For purposes of this subsection, all persons treated as a single employer under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 or subsection (m) or (o) of section 414 of such Code shall be treated as a single covered entity (or employer for purposes of paragraph (2)).

(B) INCLUSION OF FOREIGN CORPORATIONS. For purposes of subparagraph (A), in applying subsections (a) and (b) of section 52 of such Code to this section, section 1563 of such Code shall be applied without regard to subsection (b)(2)(C) thereof.

(d) UNITED STATES HEALTH RISK. For purposes of this section, the term “United States health risk” means the health risk of any individual who is— (1) a United States citizen,
(2) a resident of the United States (within the meaning of section 7701(b)(1)(A) of the Internal Revenue Code of 1986), or
(3) located in the United States, with respect to the period such individual is so located.

(e) THIRD PARTY ADMINISTRATION AGREEMENT FEES. For purposes of this section, the term “third party administration agreement fees” means, with respect to any covered entity, amounts received from such employer which are in excess of payments made by such covered entity for health benefits

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.

The percentage of third party administration agreement fees that are taken into account is:

Not more than $5,000,000 ............................................................................. 0 percent
More than $5,000,000 but not more than $10,000,000 ........................................ 50 percent
More than $10,000,000 ............................................................................. 100 percent.

With respect to a covered entity’s third party administration agreement fees during the calendar year that are:
under an arrangement under which such em-
ployer self-insures the United States health risk of its employees.

(f) Tax Treatment of Fees.—The fees imposed
under such Code, and

(1) for purposes of subtitle F of the Internal
Revenue Code of 1986, shall be treated as
exclude taxes with respect to which only civil
actions are brought after procedures of such
subtitle shall apply, and

(2) for purposes of section 275 of such Code
shall be considered to be a tax described in
section 512(a)(6).

(g) Reporting Requirement.—

(1) In General.—Not later than the date
determined by the Secretary following the end of any calendar year, each covered enti-

uty shall report to the Secretary, in such
manner as the Secretary prescribes, the cov-
ered entity's net premiums written with re-
spect to health insurance for any United
States health risk and third party adminis-
tration agreement fees for such calendar
year.

(2) Penalty for Failure to Report.—

(A) In General.—In the case of any failure
to make a report containing the information required to be reported under paragraph (1) on the date pre-
scribed therefor (determined with regard to
any extension of time for filing), unless it is
shown that such failure is due to reasonable
cause (as determined by the Secretary), by

a covered entity failing to file such report, an amount
equal to—

(i) $10,000, plus

(ii) an amount equal to $1,000, multiplied by
the number of days during which such failure
continues, or

(iii) the amount of the fee imposed by this
section for which such report was required.

(B) Treatment of Penalty.—The penalty
imposed under subparagraph (A) shall

be

(i) paid on notice and demand by the
Secretary and in the same manner as tax
under such Code, and

(ii) with respect to which only civil ac-
tions for refund under procedures of such
subtitle shall apply.

(h) Additional Definitions.—For purposes
of this section:

(1) Taxable Year.—The term "Secretary"
means the Secretary of the Treasury or the
Secretary's delegate.

(2) United States.—The term "United
States" means the several States, the Dis-

frac of Columbia, the Commonwealth of
Puerto Rico, and the possessions of the
United States.

(3) Health Insurance.—The term "health
insurance" shall not include insurance for
long-term care or disability.

(g) Guidance Necessary to Carry Out the
Purposes of This Section.

The Secretary shall publish guidance
necessary to carry out this section.

(i) Application of Section.—This section
shall apply to any net premiums written after
December 31, 2010, with respect to health
insurance for any United States health risk, and any third party administra-
tion agreement fees received after such date.

SEC. 9011. STUDY AND REPORT OF EFFECT ON
VETERANS HEALTH CARE.

(a) In General.—The Secretary of Vete-

rans Affairs shall conduct a study on the ef-
fect (if any) of the provisions of sections 9008, 9009, and 9010 on

(1) the cost of medical care provided to ve-

terans and to the Committee on Finance of the
Senate not later than December 31, 2012.

SEC. 9012. ELIMINATION OF DEDUCTION FOR
EXCISE TAXES ALLOCABLE TO MEDICARE
PAID BY CERTAIN HEALTH INSURANCE PROVIDERS.

(a) In General.—Section 159A of the Inter-

nal Revenue Code of 1986 is amended by

striking the second sentence.

(b) Effective Date.—The amendment
made by this section shall apply to taxable
years beginning after December 31, 2010.

SEC. 9013. MODIFICATION OF ITEMIZED DEDU-
CTION FOR MEDICAL EXPENSES.

(a) In General.—Subsection (a) of section

213 of the Internal Revenue Code of 1986 is amended by adding

at the end the following new subsection:

'[l] Special Rule for 2013, 2014, 2015, and 2016.—In the case of any taxable year begin-

ning after December 31, 2012, and ending be-

fore January 1, 2017, subsection (a) shall be

applied with respect to a taxpayer by substi-
tuting "7.5 percent" for "10 percent" if such
taxpayer or such taxpayer's spouse has at-
tained age 65 before the close of such taxable year.'.

(c) Conforming Amendment.—Section

56j(b)(1)(B) of the Internal Revenue Code of 1986 is amended by

striking "by substituting "10 percent" for the applicable
rate under this section" and inserting "without regard to subsection (f) of such
section".

(d) Effective Date.—The amendments
made by this section shall apply to taxable
years beginning after December 31, 2012.

SEC. 9014. LIMITATION ON EXCESSIVE REMU-
NERATION PAID BY CERTAIN HEALTH INSURANCE PROVIDERS.

(a) In General.—Section 162(m) of the Inter-

nal Revenue Code of 1986 is amended by

adding at the end the following new subpara-
graph:

'[g] Special Rule for Application to Cer-

tain Health Insurance Providers.—

(A) In General.—No deduction shall be

allowed under this chapter—

(1) in the case of applicable individual

remuneration which is for any disqualified tax-

able year beginning after December 31, 2012,

and which is services performed by an

applicable individual during such taxable

year, to the extent that the amount of such remuneration

exceeds $500,000;

(2) in the case of deferred deduction re-

muneration for such disqualified taxable year beginning after December 31, 2012, to

the extent that the amount of such remuneration

exceeds $500,000, or

(3) in the case of deferred deduction remu-

neration for any taxable year beginning after

December 31, 2012, which is attributable to

services performed by an applicable individual
during any disqualified taxable year beginning after December 31, 2009, to the ex-

tent that the amount of such remuneration exceeds

$500,000, or

(4) in the case of applicable individual

remuneration for such disqualified taxable year, plus

(5) in the case of deferred deduction remu-

neration for services performed by such

covered entity after December 31, 2009, to the extent

that the amount of such remuneration exceeds

$500,000.

(b) Deferred Deduction Remuneration.—

For purposes of this paragraph, the term "deferred

deduction remuneration" means remuneration which would be applica-
able individual remuneration for services per-
formed in a disqualified taxable year but for the

fact that the deduction under this chapter

(determined without regard to this para-

graph) for such remuneration is allowable in a

subsequent taxable year.

(c) Applicable Individual.—For purposes
of this paragraph, the term "applicable indi-

vidual" means, with respect to any covered

health insurance provider for any disquali-

fied taxable year, any employer who is a

health insurance issuer (as defined in section
9832(b)(2)) and who received from providing health insurance coverage (as de-

fined in section 9832(b)(1)), and

(d) Effective Date.—The amendment
made by this section shall apply to taxable
years beginning after December 31, 2012,

and ending before January 1, 2017, and to

any extension of time for filing, unless it is
determined that the amount of such remuneration

exceeds $500,000, or

(e) Coordination.—Rules similar to the

rules of subparagraphs (F) and (G) of para-

graph (4) shall apply for purposes of this

paragraph.

(f) Regulatory Authority.—The Secre-

tary may prescribe such guidance, rules, or

regulations as are necessary to carry out the

purposes of this paragraph.

(h) Cut-Off Date.—The amendment
made by this section shall apply to taxable
years beginning after December 31, 2012,

and which applies only to services performed
before such date.

SEC. 9015. ADDITIONAL HOSPITAL INSURANCE
TAX ON HIGH-INCOME TAXPAYERS.

(a) FICA.—

(1) In General.—Section 3121(b) of the Inter-

nal Revenue Code of 1986, is amended—

(A) by striking "In addition" and inserting the

following:

'[l] with respect to taxable years begin-

ning after December 31, 2009, and before

January 1, 2013, any employer which is a health

insurance issuer (as defined in section
9832(b)(2)) and which receives from providing health insurance coverage (as de-

fined in section 9832(b)(1)), and

(ii) with respect to taxable years begin-

ning after December 31, 2012, any employer

which is a health insurance issuer (as defined in
section 9832(b)(2)) and with respect to which

not less than 25 percent of the gross receipts
received from providing health in-

surance coverage (as defined in section
9832(b)(1)) is from minimum essential cov-

erage as defined in section 9832(b)(2));

(2) by adding at the end the following new

paragraph:

[(d)] Applicable Individual Remunera-

tion.—For purposes of this paragraph,

the term "applicable individual remunera-

tion" means remuneration which would

be applicable individual remuneration for

services performed during the disqualified

taxable year.
“(2) ADDITIONAL TAX.—In addition to the tax imposed by paragraph (1) and the preceding subsection, there is hereby imposed on every taxpayer (other than a corporation, estate, or trust) an additional tax equal to 0.5 percent of the amount of wages which are received with respect to employment (as defined in section 3121(b)) during any taxable year beginning after December 31, 2009, in excess of $200,000, and

(A) in the case of a joint return, $250,000, and

(B) in any other case, $200,000.

(2) TERMINATION.—Section 3101 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

“(1) SPECIAL RULES FOR ADDITIONAL TAX.—

“(1) IN GENERAL.—In the case of any tax imposed by section 3101(b)(2), subsection (a) shall only apply to the extent to which the taxpayer receives wages from the employer in excess of $200,000, and the employer may disregard the amount of wages received by such taxpayer’s spouse.

“(2) COLLECTION OF AMOUNTS NOT WITHHELD.—To the extent that the amount of any tax imposed by section 3101(b)(2) is not collected by the employer, such tax shall be paid by the person who performs the services for which the wages were paid.

“(3) TAX PAID BY RECIPIENT.—If an employer, in violation of this section, fails to deduct and withhold the tax imposed by section 3101(b)(2) and thereafter the tax is paid, the employer shall be entitled to a credit against the tax imposed by section 3101(b)(2) equal to the amount of the tax paid.

“(4) OTHER RULES.—No deduction for additional tax shall be permitted for any wages paid before December 31, 2009.

“(5) TRANSFER OF AMOUNTS.—The amendments made by this section shall apply to the taxable year beginning after December 31, 2009.

“CHAPTER 49—ELECTIVE COSMETIC MEDICAL PROCEDURES

“SEC. 9001B. Imposition of tax on elective cosmetic medical procedures.

“SEC. 9001C. Imposition of tax on elective cosmetic medical procedures.

“SEC. 9021. EXCLUSION OF HEALTH BENEFITS PROVIDED BY INDIAN TRIBAL GOVERNMENTS.

“SEC. 9022. ESTABLISHMENT OF SIMPLE CAFE-TERIA PLANS FOR SMALL BUSINESSES.
amended by redesignating subsections (j) and (k) as subsections (k) and (l), respectively, and by inserting after subsection (k) the following new subsection:

"(II) SIMPLE CAFETERIA PLANS FOR SMALL BUSINESSES.—

"(i) IN GENERAL.—An eligible employer maintaining a cafeteria plan with respect to which the requirements of this subsection are met for any year shall be treated as meeting any applicable nondiscrimination requirements for such year.

"(ii) SIMPLE CAFETERIA PLAN.—For purposes of this subsection, the term ‘simple cafeteria plan’ means a cafeteria plan—

(A) which is established and maintained by an eligible employer, and

(B) with respect to which the contribution requirements of paragraph (3), and the eligibility and participation requirements of paragraph (4), are met.

(3) CONTRIBUTION REQUIREMENTS.—

(A) IN GENERAL.—The requirements of this paragraph are met if, under the plan the employer is required, without regard to whether a qualified employee makes any salary reduction contribution, to make a contribution to provide qualified benefits under the plan on behalf of each qualified employee in an amount equal to—

(i) 6 percent of the percentage (not less than 2 percent) of the employee’s compensation for the plan year, or

(ii) an amount which is not less than the lesser of—

(A) 6 percent of the employee’s compensation for the plan year, or

(B) twice the amount of the salary reduction contributions of each qualified employee.

(B) MATCHING CONTRIBUTIONS ON BEHALF OF HIGHLY COMPENSATED AND KEY EMPLOYEES.—The requirements of subparagraph (A)(ii) shall not be treated as met if, under the plan, the rate of contributions with respect to any salary reduction contribution of a highly compensated or key employee at any rate of contribution is greater than that with respect to an employee who is not a highly compensated or key employee.

(C) ADDITIONAL CONTRIBUTIONS.—Subject to subparagraph (B), nothing in this paragraph shall be treated as prohibiting an employer from providing contributions to provide qualified benefits under the plan in addition to contributions required under subparagraph (A).

(D) DEFINITIONS.—For purposes of this paragraph—

(i) SALARY REDUCTION CONTRIBUTION.—The term ‘salary reduction contribution’ means, with respect to a cafeteria plan, any amount which is contributed to the plan at the election of the employee and which is not includible in gross income by reason of this section.

(ii) QUALIFIED EMPLOYEE.—The term ‘qualified employee’ means, with respect to a cafeteria plan, any employee who is a highly compensated or key employee, or who is eligible to participate in the plan.

(iii) HIGHLY COMPENSATED EMPLOYEE.—The term ‘highly compensated employee’ has the meaning given such term by section 414(q).

(iv) KEY EMPLOYEE.—The term ‘key employee’ has the meaning given such term by section 414(e).

(4) MINIMUM ELIGIBILITY AND PARTICIPATION REQUIREMENTS.—

(A) IN GENERAL.—The requirements of this paragraph shall be treated as met with respect to any employee if, under the plan—

(i) all employees who had at least 1,000 hours of service for the preceding plan year are eligible to participate, and

(ii) each employee eligible to participate in the plan may, subject to terms and conditions applicable to all participants, elect any benefit available under the plan.

(B) CERTAIN EMPLOYEES MAY BE EXCLUDED.—For purposes of subparagraph (A)(i), an employer may elect to exclude under the plan employees—

(i) who have not attained the age of 21 before the close of a plan year,

(ii) who have less than 1 year of service with the employer as of any day during the plan year,

(iii) who are covered under an agreement which the Secretary of Labor finds to be a collective bargaining agreement if there is evidence that the benefits covered under the cafeteria plan were the subject of good faith bargaining between employee representatives and the employer,

(iv) who are described in section 410(b)(3)(C) (relating to nonresident aliens working outside the United States),

(v) who are not employees who are eligible to participate in the plan as employees who are not a highly compensated or key employee.

(5) ELIGIBLE EMPLOYER.—For purposes of this subsection—

(A) IN GENERAL.—The term ‘eligible employer’ means, with respect to any year, any employer if such employer employed an average of at least 100 full-time equivalent days during either of the 2 preceding years. For purposes of this subparagraph, a year may only be taken into account if the employer was in existence throughout the year.

(B) EMPLOYERS NOT IN EXISTENCE DURING PRECEDING YEAR.—If an employer was not in existence throughout the preceding year, the determination under subparagraph (A) shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current year.

(C) GROWING EMPLOYERS RETAIN TREATMENT AS SMALL EMPLOYER.—

(i) IN GENERAL.—If—

(A) an employer was an eligible employer for any year (a ‘qualified year’), and

(B) such employer establishes a simple cafeteria plan for its employees for such year, then, notwithstanding the fact the employer fails to meet the requirements of subparagraph (A) for any subsequent year, such employer shall be treated as an eligible employer for such subsequent year with respect to employees (whether or not employees during a qualified year) of any trade or business which was covered by the plan during any qualified year.

(ii) EXCEPTION.—This subparagraph shall cease to apply if the employer employs an average of 200 or more employees on business days during any year preceding any such subsequent year.

(D) SPECIAL RULES.—

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

(ii) AGGREGATION RULES.—All persons treated as a single employer under subsection (a) or (b) of section 52, or subsection (n) or (o) of section 414, shall be treated as one person.

(E) APPLICABLE NONDISCRIMINATION REQUIREMENT.—For purposes of this subsection, the term ‘applicable nondiscrimination requirement’ means any requirement under subchapter E of chapter 1 of subpart E of part IV of the Revised Statutes as in effect on the day before the enactment of the Revenue Reconciliation Act of 1990.

(6) APPLICATION OF SUBSECTION.—An investment in a taxable year is made in 2009 or 2010.

(7) COMPENSATION.—The term ‘compensation’ has the meaning given such term by section 3401(a).
(m) or (o) of section 414, shall be so treated for purposes of this paragraph.

“(3) FACILITY MAINTENANCE EXPENSES.—The term ‘facility maintenance expenses’ means costs paid or incurred to maintain a facility, including—

“(A) mortgage or rent payments,

“(B) insurance payments,

“(C) utility and maintenance costs, and

“(D) costs of employment of maintenance personnel.

“(d) QUALIFYING THERAPEUTIC DISCOVERY PROJECT CREDIT.—

“(1) ESTABLISHMENT.—

“(A) IN GENERAL.—Not later than 60 days after the date of the enactment of this section, the Secretary may require in consultation with the Secretary of Health and Human Services, shall establish a qualifying therapeutic discovery project program to consider and award certifications for qualified investments eligible for credits under this section to qualifying therapeutic discovery project sponsors.

“(B) LIMITATION.—The total amount of credits that may be allocated under the program shall not exceed $1,000,000,000 for the 2-year period beginning with 2009.

“(2) APPLICABILITY.—

“(A) APPLICATION PERIOD.—Each applicant for certification under this paragraph shall submit an application containing such information as the Secretary may require during the period beginning on the date the Secretary establishes the program under paragraph (1).

“(B) TIME FOR REVIEW OF APPLICATIONS.—The Secretary shall take action to approve or deny any application under subparagraph (A) within 30 days of the submission of such application.

“(C) MULTI-YEAR APPLICATIONS.—An application for certification under subparagraph (A) may include a request for an allocation of credits for more than 1 year.

“(3) SELECTION CRITERIA.—In determining the qualifying therapeutic discovery projects with respect to which qualified investments may be certified under this section, the Secretary—

“(A) shall take into consideration only those projects that show reasonable potential—

“(i) to result in new therapies—

“(1) to treat areas of unmet medical need,

“(2) to prevent, detect, or treat chronic or acute diseases and conditions,

“(3) to reduce long-term health care costs in the United States,

“(4) to significantly advance the goal of curing cancer within the 30-year period beginning on the date the Secretary establishes the program under paragraph (1), and

“(B) shall take into consideration which projects have the greatest potential—

“(i) to create and sustain (directly or indirectly) high-paying jobs in the United States, and

“(ii) to advance United States competitiveness in the fields of life, biological, and medical sciences.

“(4) DISCLOSURE OF ALLOCATIONS.—The Secretary shall, upon making a certification under this subsection, publicly disclose the identity of the applicant and the amount of the credit with respect to such applicant.

“(e) SPECIFIC RULES.—

“(1) BASIS ADJUSTMENT.—For purposes of this paragraph, if a credit is allowed under this section for an expenditure related to property of a character subject to an allowance for depreciation, the basis of such property shall be reduced by the amount of such credit.

“(2) DENIAL OF DOUBLE BENEFIT.—
such form as the Secretary may require to state the amount of the credit allowable (but for the receipt of a grant under this subsection) under section 48D for the taxable year in which the investment occurred with respect to which such application is made.

(3) TIME FOR PAYMENT OF GRANT.—

(A) IN GENERAL.—The Secretary of the Treasury shall make payment of the amount of any grant under paragraph (1) during the 30-day period beginning on the later of—

(i) the date of the application for such grant; or

(ii) the date the qualified investment for which the grant is being made is made.

(B) REGULATIONS.—In the case of investments of a nature, the Secretary shall issue regulations to determine the date on which a qualified investment shall be deemed to have been made for purposes of this paragraph.

(4) QUALIFIED INVESTMENT.—For purposes of this subsection, the term "qualified investment" means a qualified investment that is certified under section 48D(d) of the Internal Revenue Code of 1986 for purposes of the credit under such section 48D.

(5) APPLICATION OF CERTAIN RULES.—

(A) IN GENERAL.—In making grants under this section, the Secretary of the Treasury shall apply rules similar to the rules of section 50 of the Internal Revenue Code of 1986.

(B) PROVISIONS OF LAW NOT APPLICABLE.—The Secretary shall not apply any provision of law to any grant made under this subsection which is also used in section 48D.

(C) EFFECTIVE DATE.—The amendments made by subsections (a) through (d) of this section shall apply to amounts paid or incurred in taxable years beginning after such date.

NOTICE OF HEARING

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. BINGAMAN. Mr. President, I would like to announce for the information of the Senate and the public that a hearing has been held before the Senator Committee on Energy and Natural Resources. The hearing will be held on Thursday, December 3, 2009, at 10 a.m., in room SD-366 of the Dirksen Senate Office Building.

The purpose of the hearing is to receive testimony on H.R. 2276, the American Medical Isotopes Production Act of 2009.

Because of the limited time available for the hearing, witnesses may testify by invitation only. However, those wishing to submit written testimony for the hearing record may do so by sending it to the Committee on Energy and Natural Resources, United States Senate, Washington, D.C. 20510–6150, or by e-mail to Rosemarie Calabro at energy.senate.gov.

For further information, please contact Jonathan Epstein at (202) 224–3357 or Rosemarie Calabro at (202) 224–5039.

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON ARMED SERVICES

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Armed Services be authorized to meet during the session of the Senate on November 19, 2009, at 9:30 a.m.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON BANKING, HOUSING, AND URBAN AFFAIRS

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Banking, Housing, and Urban Affairs be authorized to meet during the session of the Senate on November 19, 2009, at 10 a.m.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Commerce, Science, and Transportation be authorized to meet during the session of the Senate on November 19, 2009, in room 253 of the Russell Senate Office Building.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Energy and Natural Resources be authorized to meet during the session to conduct a hearing on November 19, 2009, at 10:30 a.m., in room SD-366 of the Dirksen Senate Office Building.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON FOREIGN RELATIONS

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Foreign Relations be authorized to meet during the session of the Senate on November 19, 2009, at 3:30 p.m.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Health, Education, Labor, and Pensions be authorized to meet, during the session of the Senate, to conduct a hearing entitled “Hearing on Nominations for Confirmations and for General Counsel of the Equal Employment Opportunity Commission” on November 19, 2009. The hearing will commence at 10 a.m. in room 430 of the Dirksen Senate Office Building.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Homeland Security and Governmental Affairs be authorized to meet during the session of the Senate on November 19, 2009, at 10 a.m. to conduct a hearing entitled “The Fort Hood Attack: A Preliminary Assessment.”

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Homeland Security and Governmental Affairs be authorized to meet during the session of the Senate on November 19, 2009, at 10 a.m. to conduct a hearing entitled “The Fort Hood Attack: A Preliminary Assessment.”

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON INDIAN AFFAIRS

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Indian Affairs be authorized to meet during the session of the Senate on November 19, 2009, at 2:30 p.m.

The PRESIDING OFFICER. Without objection, it is so ordered.
Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on the Judiciary be authorized to meet during the session of the Senate, on November 19, 2009, at 10 a.m. in SD-226 of the Dirksen Senate Office Building, to conduct an executive business meeting.

The PRESIDING OFFICER. Without objection, it is so ordered.

SELECT COMMITTEE ON INTELLIGENCE

Mr. DURBIN. Mr. President, I ask unanimous consent that the Select Committee on Intelligence be authorized to meet during the session of the Senate on November 19, 2009, at 2:30 p.m.

The PRESIDING OFFICER. Without objection, it is so ordered.

PRIVILEGES OF THE FLOOR

Mr. AKAKA. Mr. President, I ask unanimous consent that Dr. Andrea Buck, a physician detailed to the Vermont Affairs Committee staff from the VA Inspector General’s Office be granted the privilege of the floor for the duration of the debate on S. 1963.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. LEAHY. Mr. President, I ask unanimous consent that Randoe Dice, a legislative clerk will report the resolution by unanimous consent for Randoe Dice, a legislative clerk.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. AKAKA. Mr. President, I ask unanimous consent that Rachel Pelham of my staff be given the privilege of the floor for the rest of the day.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. AKAKA. Mr. President, I ask unanimous consent for Randoe Dice, a legislative clerk.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. AKAKA. Mr. President, I ask unanimous consent that Rachel Pelham of my staff be given the privilege of the floor during the debate on S. 1963.

The PRESIDING OFFICER. Without objection, it is so ordered.

IRAN’S HUMAN RIGHTS VIOLATIONS

Mr. KAUFMAN. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of S. Res. 355, submitted earlier today.

The PRESIDING OFFICER. The clerk will report the resolution by title.

The legislative clerk read as follows:

A resolution (S. Res. 355) expressing the sense of the Senate that the Government of the Islamic Republic of Iran has systematically violated its obligations to uphold human rights provided for under its constitution and international law.

There being no objection, the Senate proceeded to consider the resolution.

Mr. GRASSLEY. Mr. President, recent events have made abundantly clear that the Government of the Islamic Republic of Iran is failing, and failing badly, to live up to its own professed ideals and its international commitments to protect the human rights of its citizens. I urge my colleagues to join with me in supporting a resolution, S. Res. 355, submitted today, condemning Iran’s deplorable human rights record, calling for an immediate release of those wrongfully imprisoned in violation of their rights, and urging the restoration of meaningful human rights to all of Iran’s citizens.

Iran’s 1979 constitution, the result of a revolution against years of political and human-rights abuses by the regime of the Shah, guarantees fundamental rights and freedoms. Moreover, Iran is a signatory to four major human rights treaties; yet its shameful record of executions that contravene international standards; of repression of the rights of women and minorities, including religious minorities; of outrageous attacks on the rights of peaceful assembly and protest; and of unwaranted arrest and detention of foreigners, including Americans, all make a mockery of these commitments.

Just last week, the Iranian Government again demonstrated its contempt for human rights and the rule of law when it announced it would pursue espionage charges against three young Americans who crossed Iran’s border with Iraq. These allegations are just the latest telling example on a long list of abuses.

American Robert Levinson has been missing in Iran for more than two years, during which the Iranian regime has denied having any information on whereabouts and has blocked international attempts to discover his fate. In January 2009, the Iranian Government jailed Iranian-American journalist Roxana Saberi and charged and convicted her of espionage after a one-hour show trial that mocked even the most basic standards of due process and law, and then sentenced her to eight years in prison before releasing her a few months later. Esha Momeni, a student at California State University, Northridge, was imprisoned last fall for her peaceful activities in support of women’s rights in Iran. The regime’s abuses have even touched Nobel peace prize winner Shirin Ebadi, whose Center for Defenders of Human Rights was forced to close by the government in December 2008.

None of these recent abuses, however, as deplorable as they are, have shocked the conscience of the world so severely as the Iranian Government’s actions in response to this year’s disputed presidential elections. Prompted by justifiable concerns, all had been thwarted in a rigged election, thousands of Iranian citizens took to the streets, firmly but peacefully exercising their rights and demanding the democracy their government purports to embody. The regime’s response was to launch violent, heavy-handed attacks against these peaceful protestors, using government security forces and paramilitary militias under government control to repress the legitimate expression of a valid grievance.

The United Nations High Commissioner for Human Rights reports that this violence resulted in at least a dozen deaths, and hundreds of injuries.

In the aftermath, the Iranian Government imprisoned dozens of its citizens and conducted a mass trial of more than 100 of them, many of whom bore clear signs of physical abuse. The government sentenced at least four of these prisoners to death on the basis of dubious confessions, likely produced under duress and abuse.

It is proper and appropriate for the Senate to make clear its determination that these acts violate international human rights standards. Iran’s own professed commitments and common decency. The resolution introduced today would record the Senate’s condemnation of Iran’s woeful human rights record; remind the Iranian government of its domestic and international commitments to human rights; call for the immediate release of all those held for their peaceful exercise of rights of free expression, assembly and association; and urge Iran to extend full legal rights to those imprisoned for exercising their government’s purported rights of free speech, a free press, free expression of religion, freedom of association, and freedom of assembly.

It is a tragic irony that the government perpetrating these deplorable acts of violence and abuse came to power three decades ago because the Iranian people rejected the abuses and violence of a previous regime. Now following in the repressive footsteps of that previous regime, the current Iranian Government has been widely condemned by the community of nations. Passage of this resolution would add the U.S. Senate’s loud and clear voice of condemnation to the many voices inside Iran, and out, calling for the restoration of basic human rights for the Iranian people.

Mr. KAUFMAN. I ask unanimous consent that the resolution be agreed to, the preamble be agreed to, and the motions to reconsider be laid upon the table on en bloc; that any statements relating to the resolution be printed in the Record without intervening action or debate.

The PRESIDING OFFICER. Without objection, it is so ordered.

The resolution (S. Res. 355) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

Whereas the 1979 Constitution of the Islamic Republic of Iran supposedly guarantees certain human rights and fundamental freedoms, which encompass civil and political rights, along with economic, social, and cultural rights;

Whereas the Islamic Republic of Iran is a party to four major United Nations human rights treaties: the Covenant on Civil and Political Rights, the Convention on the Rights of the Child (which it ratified on July 13, 1994), the International Convention on the
Elimination of All Forms of Racial Discrimination (which it ratified on August 29, 1968), and the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights (both of which it ratified on June 24, 1975); 

Whereas the Government of Iran has routinely violated the human rights of its citizens, including—

(1) torture and cruel, inhuman, or degrading treatment or punishment, including flogging, and amputations; 
(2) high incidence and increase in the rate of executions carried out in the absence of internationally recognized safeguards, including public executions and executions of juvenile offenders; 
(3) stoning as a method of execution and persons in prison who continue to face sentences of execution by stoning; 
(4) arrests, violent repression, and sentencing of women exercising their right to peaceful assembly, a campaign of intimidation against women’s rights defenders, and continuing discrimination against women and girls; 
(5) increasing discrimination and other human rights violations against persons belonging to religious, ethnic, linguistic, or other minorities; 
(6) ongoing, systematic, and serious restrictions of peaceful assembly and association and freedom of opinion and expression, including the continuing closures of media outlets, arrests of journalists, and the censorship of expression in online forums such as blogs and websites; and 
(7) severe limitations and restrictions on freedom of religion and belief, including arbitrary and indefinite detention, and lengthy jail sentences for those exercising their right to freedom of religion or belief, including a provision in the proposed draft penal code that mandates a mandatory death sentence for apostasy, the abandoning of one’s faith; 

Whereas, since March 9, 2007, Robert Levinson, a graduate student at California State University, Northridge, for her peaceful activities in connection with the women’s rights movement in the Islamic Republic of Iran, has been missing in the Islamic Republic of Iran, and the Government of Iran has provided little information on his whereabouts or assistance in ensuring his safe return to the United States; 

Whereas Jafar Kiani was publicly stoned to death in July 2007 in the Islamic Republic of Iran; 

Whereas, in early October 2009, the judiciary of the Islamic Republic of Iran sentenced four individuals to death after the disputed presidential election, without providing the individuals adequate access to legal representation during their trials; 

Whereas the Supreme Leader of Iran, Ali Khamenei, issued a statement on October 28, 2009, effectively criminalizing dissent regarding the national election in the Islamic Republic of Iran this past June, further restricting the right to freedom of expression; 

Whereas the Government of Iran does not allow independent nongovernmental associations and labor unions to perform their role in peacefully defending the rights of all persons; 

Whereas, on November 4, 2009, security forces in the Islamic Republic of Iran used brutal force and excessive violence against protesters, resulting in a number of injuries and arrests, in violation of international standards regarding the proportionate use of force against peaceful demonstrations; 

Whereas the Government of Iran expelled students from universities, particularly over the past two years, in reprimal for their being critical of the government; 

Whereas the Government of Iran has imposed restrictions on the travel of individuals, including students, journalists, and the recent elections, in reprisal for their political views or their criticism of the government, such as those presently imposed on human rights lawyer Abdolfattah Soltani, human rights activist Emad Baghi, film director Jafar Panahi, and actress Fatemeh Motamed Arya; and 

Whereas, according to Amnesty International, at least 346 people were known to have been executed in 2008, including eight juvenile offenders and two men who were executed by stoning; therefore, be it 

Resolved, That the Senate—

(1) calls for authorities in the Islamic Republic of Iran to respect the rights of the people of Iran to freedom of speech, press, religion, association, and assembly; 
(2) condemns the Government of Iran’s human rights violations and calls on the Government of Iran to hold those responsible accountable for their actions; 
(3) reminds the Government of Iran of its constitutional obligations under its 1979 Constitution and four international covenants to which it is a signatory; 
(4) calls for the immediate release from detention of all political prisoners, human rights defenders, journalists, and all others held for peacefully exercising their right to expression, assembly, and association; 
(5) urges the Government of Iran to ensure that anyone placed on trial for committing acts of violence or other clearly criminal acts benefits from all of his or her rights to a fair trial, including proceedings that are open to the public, the right to be represented by independent counsel, and guarantees that no statements shall be admitted into evidence that have been obtained through torture, inhumane, or degrading treatment; 
(6) calls for the Government of Iran to ensure that all human rights violations and abuses are treated humanely, to provide detainees immediate prompt access to their families, lawyers, and any medical treatment that may be needed, and calls for the Government of Iran to hold accountable those responsible for torture of detainees; and 
(7) calls for authorities in the Islamic Republic of Iran, consistent with their obligations under the International Covenant on Civil and Political Rights, to guarantee all persons the “freedoms to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing, or in print, in the form of art, or through any other media of his choice”.

ORDER FOR PRINTING OF AMENDMENT NO. 2786

Mr. KAUFMAN. I ask unanimous consent that amendment No. 2786 be printed.

APPOINTMENT

The PRESIDING OFFICER. The Chair, on behalf of the President pro tempore, and in consultation with the ranking member of the Senate Committee on Finance, pursuant to Public Law 103-296, appoints Jagadeesh Gokhale, of Maryland, vice Sylvester Schieber, of Michigan, as a member of the Social Security Advisory Board.

ORDERS FOR FRIDAY, NOVEMBER 20, 2009

Mr. KAUFMAN. Mr. President, I ask unanimous consent that when the Senate completes its business today, it adjourn until 9:45 a.m. tomorrow, Friday, November 20, that following the prayer and pledge, the Journal of proceedings be approved to date, the morning hour be deemed expired, the time for the two leaders be reserved for their use later in the day, and the Senate resume debate on the motion to proceed to H.R. 3590, as provided for under the previous order.

The PRESIDING OFFICER. Without objection, it is so ordered.

PROGRAM

Mr. KAUFMAN. Mr. President, there will be no rollcall votes during tomorrow’s session of the Senate. The next vote will occur at 8 p.m. on Saturday, November 21. That vote will be on the motion to invoke cloture on the motion to proceed to H.R. 3590.

ORDER FOR ADJOURNMENT

Mr. KAUFMAN. If there is no further business to come before the Senate, I ask unanimous consent that it adjourn under the previous order, following the remarks of Senators BROWNBACK and HATCH.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from Utah. 

Mr. HATCH. Mr. President, I thank my colleague.
HEALTH CARE REFORM

Mr. HATCH. Mr. President, I would like to take my time to talk about the critical issue of health care reform as this body stands at a historic crossroad on this national challenge.

We have never seen anything like the issues we are facing last year. The line between private businesses and public government has never been so blurred. Just look at this chart I have in the Chamber. Government effectively owns several of our Nation’s institutions, from biotechnology companies to financial institutions, banks and automobile manufacturers. CEOs have been fired by government bureaucrats, and Washington is now in the business of dictating salaries in the private sector.

With government takeovers on the rise, drastic labor law changes being pushed forward, and sweeping new corporate taxes circling overhead, we are truly moving toward a European-style government at a time when most European countries are moving away from it. I deliver these remarks with a heavy heart because what could have been a strong, bipartisan bill reflecting our collective and genuine desire for responsible health care reform on one-sixth of the American economy continues to be an extremely partisan exercise, pushing for more Federal spending, bigger government, and higher taxes as a flawed solution.

At the outset, let me make one point as clear as possible. We are all for reform, everybody on this floor. Every Republican colleague whom I have talked to wants to reform our current health care system. Ensuring access to affordable and quality health care for every American is not a Republican nor is it a Democrat issue or idea; it is an American issue. Our Nation expects us to solve this challenge in an open, honest, and responsible manner.

Clearly, health care spending continues to rise fast. This year will mark the largest ever 1-year jump in the health care share of our GDP—a full percentage point, to 17.6 percent. Growing health care costs translate directly into higher coverage costs.

Since the last decade, the cost of health care coverage has increased by 120 percent—three times the growth of inflation and four times the growth of wages. Rising costs is the primary driver behind why we continue to see a rising national deficit. We are not merely in the second inning of a baseball game and why an increasing number of businesses find it hard to compete in a global market. Without addressing this central problem, we cannot have a real and sustainable health care reform bill.

Unfortunately, the Senate health bill, according to the nonpartisan Congressional Budget Office, will actually increase Federal spending by $160 billion in the next 10 years instead of lowering it. Mr. President, you heard me right: spending me.

After the rushed stimulus bill, Americans are rightly concerned about what is being pushed through this Democratic Congress. The rush to pass something that will affect every American life and business has raised concerns all around our Nation. In a recent Gallup Poll, a majority of Americans believed their health care costs could actually get worse under the Democratic health care bill. Why are Americans so skeptical and concerned? Because they are being promised the impossible. They are being told that this trillion-dollar addition of taxpayer dollars to our health care system will actually cut costs and not raise their taxes, and it will reduce the Federal deficit. Even David Copperfield would be hard pressed to pull off this trick.

Many Americans recently had a firsthand encounter with the efficiency of the Federal Government in administering the H1N1 vaccination around the country. Their experience consisted of standing in long lines for several hours in sterile government buildings, only to be told they were suddenly out of doses.

Republicans in Congress agree with the majority of Americans who believe that just throwing more hard-earned taxpayer dollars at a problem will not provide timely telling the American people that the solution for solving a $2 trillion health care system is to simply spend another $2.5 trillion just does not make sense.

With nearly a half trillion dollars in new taxes, this is a textbook example of the liberal tax-and-spend philosophy. Now compare that with the Constitution of the United States. This little booklet contains the whole Constitution of the United States. Yet we have a health care bill that is 2,024 pages long. Come on. That is an example of the liberal tax-and-spend philosophy we see around here.

Here are some of the highlights of this piece—this piece of equipment, this bill, this massive, massive bill; I can hardly lift the darn thing—$28 billion in new taxes on employers through a mandate that will disproportionately affect low-income Americans, and all at a time when unemployment is over 10 percent of the entire economy. This is the largest yearly deficit since 1945. This should send shivers down the spine of every American out there. We are literally drowning this Nation and its future in a sea of red ink.

The biggest bait-and-switch on the American people about the bill’s impact on the deficit is a simple math trick. If something is expensive to do for a full 10-year period, just do it for 5 years and call it 10 years. Most of the major spending provisions of the bill do not go into effect until 2014 or even later—coincidentally, after the 2012 Presidential elections. So what we are betting is not a full 10-year score but, rather, a 5- to 6-year score.

Now chart 3: This is the real cost of the Senate plan. The CBO score—because it only scores, really, basically 5 or 6 years because major provisions of the bill are not implemented until 2014, in some respects up to 2015—they claim, is only $849 billion, or less than $1 trillion. But the full 10-year score, according to the Senate Budget Committee, fully implemented, if you do it full 10 years, is $2.5 trillion. The House bill is even worse at a more astonishing level of $3 trillion.

Let me go to chart 4, because in our current fiscal environment, where the government will have to borrow nearly 40 cents of every $1 it spends this year, let’s think hard about what we are doing to our country and our future generations.

For months, I have been pushing for a fiscally responsible and step-by-step proposal that recognizes our current need for spending restraints while starting us on a path to sustainable health care reform. There are several areas of consensus that can form the
Republicans have put forth ideas, both comprehensive and incremental, through this health care reform debate, especially during committee considerations.

These ideas were either summarily rejected on party line votes or simply stripped out in the dark of the night before the final version was released. And this version is no exception. This version was done in the back rooms of the Capitol with the White House and very few Senators cobbling together what they thought would be a compromise between the HELP bill and the Finance Committee bill, and maybe even with some consideration to the House bill. There was no real bipartisan work on this bill. There was no real attempt to try and bring people together. It was strictly a partisan bill, as have been the HELP Committee bill, primarily the Finance Committee bill, and above all, the House bill.

I am opposed absolutely that the President and the Democratic leadership in the House and the Senate have chosen to pursue the creation of a new government-run plan—one of the most divisive issues in health care reform—rather than focusing on broad areas of compromise and a broad-based bi-partisan health care reform legislation. At a time when major government programs such as Medicare and Medicaid are already on a path to fiscal insolvency, creating a brand new government-run plan is too important to our long-term financial outlook. To put this in perspective, as of this year, Medicare has a liability of almost $38 trillion, which, in turn, translates into a financial burden of more than $300,000 per American family over time.

So what is the Washington solution to address this crisis? We will take up to $500 billion out of this bankrupt program and use it to expand another bankrupt program—Medicaid—and create a brand new government-run plan, a Washington government-run plan. I am not an economist, but I know that the money that once flowed into the American health care system is now flowing into the American financial system. We should be reforming Medicare and Medicaid for our people, but instead we keep spending, and to take $500 billion out of Medicare which has a $38 trillion unfunded liability to create another government run program I think is immoral. It is certainly not what the American people want and it is not what we, when they see what is going on, want. It is not what the American people want. It is not what they are supporting. This is the bill. My gosh, 2,074 pages. This thing right here. This is the bill. My gosh, 2,074 pages. Tolstoy’s “War and Peace” was about a little more than 1400 pages. This is a bill—we ought to have at least 72 hours to review these 2,074 pages before beginning any Senate floor action.

We are going to vote on Saturday at 8 o’clock on whether we should proceed, but it won’t be proceeding to this bill, it is going to be proceeding to a shell bill. If they proceed, then they will bring up a substitute bill which will be the bill they have worked on for 6 weeks in closed rooms. It will be a shell bill that will get it going. It is a shell game, between you and me, and me and you, and me and me, and me and me—all the way in Washington by people who believe the Federal Government is the last answer to everything.

As a bill that affects every American life and every American business, 2,074 pages is too big and it is too important not to have full public review. In fact, I think 72 hours is not enough. We need a lot more time. We are talking about one-sixth of the American economy.

To enact true health care reform, we have to come together as one to write a responsible bill for the American families who are facing rising unemployment and out-of-control health care costs.

Our national debt is ready to double in the next 5 years. Look at that. The red lines are the projected national debt under the current administration. That debt is projected to double in the next 5 years and triple in the next 10 years. Let me tell you who catches onto this. It is our friends over in China to whom we owe $800 billion. Think about it. They are concerned about the devaluation of the American dollar because they see us being profligate here in Washington.

This allow down let’s not be too quick to think about what we are doing to our future generations. I think there is still time to press the reset button and write a bill together that every one of us can support and be proud of. Right now, Republicans aren’t just standing in the way. We actually believe we can do a bipartisan bill if we had a chance, if we had a real, good faith effort by both sides. The HELP Committee bill wasn’t done that way. We did have a markup in the HELP Committee and almost a vote on a bipartisan bill. It was voted down on a party line vote. The same thing basically happened in the Finance Committee, although I have to
say that the distinguished Senator from Montana, the chairman of the Finance Committee, made every effort to try and bring people together. I give him a lot of credit for it. But he was so severely restricted by his side that there were not a whole lot of people who could support it. I was a member of the Gang of 7, but I began to realize what the final bill was going to be. I couldn't support it, so I thought the honorable thing to do, instead of coming out of every one of our meetings and finding fault with what they were talking about, was to leave the Gang of 7, and I did that. I felt bad doing it because I wanted to help work on a bipartisan bill. But the distinguished chairman was so restricted by his side that there was no way we could have a bipartisan bill out of that committee. It is disappointing to me, as somebody who has worked on so many health care matters over the years—everything from Hatch-Waxman to the orphan drug bill to the CHIP bill—to this bill—that we haven't got the guts or the ability to sit down and work this thing out together.

Now we are going to get sold a bill of goods here that doesn't make sense. This is a travesty. It is a travesty. It is hard to believe they think they can pawn this off on the American people. My gosh. I know some of the folks who have done this are well intentioned, but not for this stuff. I was going to say something else, but I want to be very kind.

The Constitution—is this the whole Constitution, the most important document, political document in the history of the world. Plus it has a lot of interesting material in the back, plus an index and so forth, but that is it, right there. Here is what one-sixth of the American economy is going to be if we allow it to go forward. I personally believe we ought to kill this bill and then sit down and do a bill that will help work on a bipartisan bill. But the distinguished chairman was so restricted by his side that there was no way we could have a bipartisan bill out of that committee. It is disappointing to me, as somebody who has worked on so many health care matters over the years—everything from Hatch-Waxman to the orphan drug bill to the CHIP bill—to this bill—that we haven't got the guts or the ability to sit down and work this thing out together.

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Then there is the idea that we are going to cut $400 billion out of Medicare, which is already on a fiscally irresponsible track and going broke. We are going to take $400 billion out of that. That is not going to happen. If it did happen, we would bankrupt Medicare. This is a bad idea at a bad time. We should not do this. We should not do it this way.

I want to focus more of my comments on a narrower piece of this, which has gotten a lot of focus in the House and should get focus in the Senate. It is the radical expansion of Federal funding of abortions that is in this bill. Let’s put it on its bottom line. They should put the Stupak language in the Senate bill, and instead the Capps language is in the bill. The Capps language will expand Federal financing of abortion—Federal taxpayer funding of abortion. The Stupak language is something we have supported here for 30 years. It is the Hyde language, a language that 64 Democrats voted for in the House. Instead, in this bill you have Federal taxpayer funding of abortions, something we have not done for 30 years. They are going to build it into this bill. The President has said that he wants—he has said multiple times it is one of his goals to lower the incidence of abortion. This bill, if we pass it, will provide, for the first time in 30 years, taxpayer funding of abortion and will expand abortions—counters to what the President has said multiple times.

Nobody who is pro-life should vote for this bill. This is a radical expansion of abortion funding. It is a radical expansion of abortion. I was and remain very disappointed that the Senate leadership and my Democratic colleagues have attempted to insert radical abortion policy through the Democratic health care bill. Abortion is not health care. Any Senator who votes on the motion to proceed to this bill, who is voting in favor of abortion and the expansion of abortion and against life. This is the biggest pro-life vote in the Senate in years. This will have more impact on abortions in the United States—an expansion of it—than anything we have seen in years. We have been on a downward trajectory on abortion because both sides have agreed; Democrats have said abortions should be safe, legal, and rare. Former President Clinton and others have said this will make taxpayer funding of abortion—this will expand it. And there is nothing rare about it.

Relevant abortion language in the health care bill to which I am referring could be found on pages 116 to 124. The National Right to Life Committee described the language and said it is completely unacceptable. The Democratic health care bill would explicitly authorize abortion to be covered under the government option, and there must be abortion coverage in every insurance market in the country. The abortion language included in the bill is a radical departure from over 30 years of bipartisan Federal policy prohibiting Federal taxpayer dollars from paying for elective abortions. The language in the bill explicitly authorizes the Secretary of Health and Human Services to include abortion in the public option and permits government subsidies in plans that pay for abortion. We have had a long dispute in Congress and in this body about abortion. We have not had a dispute near that degree—some point the finger of dispute on the taxpayer funding of abortion, because most people are opposed to that—most people in America. They may say, OK, I am all right with abortion, but I don’t support Federal taxpayer funding of it. It has been a broad, bipartisan support here for some time. It is explicitly in this bill. It is the Capps language. It is commonly referred to as that. It is in the Senate bill and contains a clever accounting gimmick that proposes to say separate private and public fundings of abortion coverage.

However, it has been proven that the Capps measure would include both abortion coverage and funding in the government option as well as for those plans in the insurance exchange.

The only acceptable abortion language is the Stupak-Pitts amendment that passed the House this fall with a quarter of the Democrat caucus voting for it—64 Democrats voted for the Stupak-Pitts compromise language. Representative Bart Stupak, the Democratic author, tailored the true compromise amendment on abortion with the principles set forth in the Hyde amendment, which has been the long-standing position of the Congress. The Hyde amendment simply says we will not use Federal funds for abortion, which is supported by a majority of Americans. The Hyde amendment has always enjoyed bipartisan support since its inception in 1977, over three decades ago.

What we should have in the health bill is language that applies the Hyde amendment as it already applies to all other federally funded health care programs, including SCHIP, Medicare, Medicaid, Indian health services, veterans health, military health care programs, and the Federal Employees Health Benefits Program. That is what should be in this.

Representative STUPAK explained the issue very clearly in an op-ed. He wrote yesterday:

The Capps amendment (which is the basis of the Senate language) departed from Hyde in several important and troubling ways: by mandating that at least one plan in the health insurance exchange provide abortion coverage, by requiring a minimum $1 monthly charge for all covered individuals that would go toward paying for abortions and by allowing individuals receiving federal affordability credits to purchase health insurance plans that cover abortion.... Hyde currently prohibits direct federal funding of abortion. The Stupak amendment is a continuation of this policy—nothing more, nothing less.

I commend Representative STUPAK for his hard work and ability to reach across the aisle to engage his Democratic and Republican colleagues on this issue. A quarter of the Democrats found the Stupak-Pitts compromise worthy of support. But a majority of the American people want keeping the Hyde principles in the Senate health care bill.

I hope we can convince our colleagues in the Senate to follow Mr. STUPAK’s lead and do the right thing and vote against the motion to proceed. Voting for the motion to proceed is to endorse the Capps language, which is an expansion of Federal taxpayer funding of abortion.

The American people agree with the Stupak compromise, not the phony language in the Senate bill that would federally fund abortions.

The American people agree it is wrong to smuggle radical abortion policy into this health care bill. The American people feel they know that forcing taxpayers to fund abortions is fiscally irresponsible and morally indefensible.

Beyond the funding issue, the Senate bill also does not include the codification of the Hyde-Weldon conscience provision. Instead, it replaces real conscience protections with language that violates the human dignity and religious freedom of organizations and religious institutions that have moral objections to participating in abortion.

A provision on page 122 reads:

No individual health care provider or health care facility may be discriminated against because of a willingness or unwillingness, if doing so is contrary to the religious or moral beliefs of the provider or facility, to provide, pay for, provide coverage of, or refer for abortion.

One other objection for the pro-life community is that there is nothing in the bill that would prevent school-based health clinics from referring for abortion or helping minors make arrangements for abortions without parental knowledge.

The administrators running the Medical Islamic Program from 1973 to 1976 were funded as many as 300,000 abortions per year, until the Hyde amendment was enacted in 1976. In the past, in that period from 1973 to 1977, when there was Federal funding of abortions, the Federal government—the taxpayers—funded as many as 300,000 abortions, then later with taxpayer dollars. That was until the Hyde amendment was enacted in 1976, because the American people despise
Mr. WHITEHOUSE. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. WHITEHOUSE. Mr. President, I rise in the course of debate, this greatest deliberative body, to speak about the upcoming debate on health care on which, thanks to the extraordinary work of our leader, Senator HARRY REID, we are about to embark. I am here to urge that we in the Senate lift the tone and direction of our national debate.

Let me start by saying I appreciate and enjoy vigorous debate. Senator BYRD gave an eloquent eulogy for Senator Kennedy, noting that our beloved, late colleague saw politics as a contact sport. There is nothing wrong with a clean hit in the public arena. Nobody here needs to tiptoe around. A well-marshaled argument, buttressed by the facts, is a beautiful thing, even when delivered with truth showing how vigorous debate is how a democracy sorts through the thorny issues we face.

What an ideal time now would be for strong, reasoned arguments about health care reform in the Senate in the coming weeks. Contrast what we have heard for months on the airwaves and in town-hall meetings: charged buzzwords such as "death panels," "socialized medicine," "benefits for illegal immigrants," "rationing of care"—words that inflame passions and ignite fear rather than making a reasoned case for advancing an alternative.

Worse, these messages have been delivered with a crudeness and a venom; for example, the President portrayed with a Hitler mustache. That is unprecedented in my experience in government. Many of us felt President Bush was less than truthful, but for 8 years, no one yelled out in a State of the Union Address: "You lie." Yet this September, 179 Republicans in the House of Representatives of the Congress of the United States voted to support their heckler comrade.

The media, so often in our history a check on the use of falsehood and distortion by powerful interests, has too often been a part of the problem, not part of the solution. For significant parts of the media, facts do not need to be true to be repeated, conclusions do not need to be logical to be reached, and spin is the order of the day.

FOX News the other day launched an attack on President Obama for having too many so-called czars. Let's set aside that George Bush had more. FOX showed a graphic of 30 officials whom it said, "didn't have to be confirmed." 9 of whom actually had been confirmed by this Senate. My young niece did a better fact-checking job at her summer job for a literary magazine than that. Recently, FOX used footage from a different event to make attendance at a Republican rally look bigger. A constituent sent me a letter expressing concern that she heard on the Glenn Beck show that President Obama was planning a national civilian security force that would report only to him, akin to the Nazi SS. What did I think of that, she asked. This was a well-meaning Rhode Islander.

This morning, the President turned out to have given a speech about expanding the Peace Corps, AmeriCorps, the Foreign Service, and other government service programs. I ask you, Mr. President, in what fevered and distorted imagination does national service programs such as AmeriCorps, to the Peace Corps or in the Foreign Service become an SS-type militia? Yet Mr. Beck actually said that.

Another rightwing piece on President Obama's support for AmeriCorps suggested a parallel with Hitler Youth.

Its author said: "If I need to make my point, I'm going to make it in a provocative manner, because that's how it attracts attention."

The truth should provide terrets through which arguments must run—but not now. As a very well-regarded Philadelphia columnist wrote of the Republican right, "if they can get some mileage . . . nothing else matters."

He went on to decry the "conservative parallel—fascist lunacy" afoot in our national debate.

The editor of the Manchester Journal Inquirer editorial page wrote of the GOP, which he called this "once great and mostly shutdown party," that it "has gone crazy," that it is "more and more dominated by the lunatic fringe," and that it has "poisoned itself with hate."

He concluded: "They no longer want to govern. They want to emote."

The respected Maureen Dowd of the New York Times, in her column eulogizing her friend, the late William Safire, lamented the "vile and vitriol of today's howling pack of conservative practitioners."

Even the staid, old U.S. Chamber of Commerce has descended into such irresponsible advocacy that Apple, PG&E, Levi Strauss & Company, PNM Resources, Nike, and Exelon have distanced themselves from it, PNM citing the Chamber's "recent theatrics."

There comes a point when debate unhinges from reality. When that happens, you leave the sunlit fields of argument and deliberation and you enter the shadowy realm of sloganeering, fear mongering, and propaganda. In these dark and twisted Halls, democracy suffers as debate seeks to scare people or deceive them rather than informing or explaining. It is so easy if you want to go there."

Of course, you can get seniors up in arms by telling them their final years will be subject to the whims of death panels. Of course, you can inflame the passions of people without health insurance by telling them their tax dollars will go to provide health insurance to illegal immigrants. Of course, you can provoke people's attention by telling them reform will keep them from doing this. They disagree with that. Whether they are pro-choice or pro-life, they don't want taxpayer dollars to go for this. If they are pro-life, they are saying those are my taxpayer dollars and I am funding this, which I so disagree with too. This is a beautiful, dignified human life, and my dollars are being used to kill it.

When the Commonwealth of Massachusetts recently passed its State-managed insurance, Commonwealth Care, with no exclusion of abortion, abortion there were also funded immediately. In fact, according to the Commonwealth Care Web site, abortion is considered covered "outpatient medical care." The Federal Government should not go down this road.

As stated earlier, the President has stated on multiple occasions that it is his goal to lower the incidence of abortion. The current language of the Senate bill would accomplish the opposite and increase abortions. If you are a pro-life Senator, you cannot vote for this bill. This is an expansion. You cannot vote for the procedural vote to go to the bill for the expansion that this will do.

In summary, I will make it clear that the President's language is what we need to fix the shell game that would allow public funds to pay for the destruction of innocent human life in the Senate health bill. Unfortunately, language currently within the health bill is a nonstarter and is wrong. It doesn't apply to the longstanding principles of the Hyde amendment. Let's maintain the status quo and not get into the business of publicly funding abortions in America.

I urge my colleagues to think seriously about the precedent being lined up in the health bill if the Senate decides it is going to force the American public to pay for abortions, whether they agree or not.

I urge my colleagues to vote against the motion to proceed to this health care bill. This is not just a procedural vote. It is an enormously important vote because it is the one opportunity for the Senate to stand for life and against Federal funding of abortions. Voting in favor of this motion to proceed is a vote against life.

I remind my colleagues, this is the biggest vote on abortion in the Senate in years. Let's not change our current Federal law to force the American public to pay for government-subsidized abortions, please.

I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.
their doctors. But none of these claims is true.

The respected head of the Mayo Clinic recently described the health care antics we have witnessed as “mud” and “scare tactics.”

A well-regarded Washington Post writer with a quarter century of experience, married to a Bush administration official, noted about the House health care bill: “The appalling amount of misinformation being peddled by its opponents.” She called it a “flood of sheer factual misstatements about the health-care bill” and noted of the House Republicans that “[t]he falsehood-peddling began at the top.

Her ultimate question was this:
Are the Republican arguments against the bill so weak that they have to resort to these misrepresentations and distortions?

Where does this lead? The ill-informed, the gullible, those already on the razor’s edge of anger about the very election of this President may well be tipped by all this poisonous propaganda into actions we would all regret—I hope we would all regret. When does some havoc occur, such that we all look back with sorrow and wish we had better leashed our dogs of rheotical war? Where do we restore civility and reason to the health care debate before it gets too late?

I say history’s charge to the Senate is to rise above the poison of our recent public debate. This greatest deliberative body is intended to set an example for public argument, not get swept into its downward spiral. We may find agreement; we may not. At the end of the day, some of us may be happy and others of us not. Some may lose and some may win. But the Senate will go on.

After the health care debate has raged through this great Chamber, other debates will follow, and ultimately what will matter more than the outcome of those debates is whether our proud American democracy has come through them with its head held high.

When debate and our democracy lose its footing in the facts, when things are said for public effect without regard to whether they are true, when the din of strife blots out the voice of reason, something of great and lasting value to America is lost.

Democracy does not prosper on a diet of propaganda and fear. The current tone of much of our debate is, frankly, unworthy of us. Most in America agree something must be done to fix our health care system. If we can agree something must be done, it should not be difficult to debate our differences as to what must be done in a civil, thoughtful, and factual manner. Let the Senate be the place where we take a stand, rejecting the incivility and falsehood that has surrounded us on our public airwaves. Through history, that is what this Chamber, at its best, has always achieved and needs now to achieve again.

UNANIMOUS CONSENT AGREEMENT—H.R. 3590

Mr. WHITEHOUSE. Mr. President, I ask unanimous consent that the Senate resume the motion to proceed to H.R. 3590 at 10 a.m. under the debate limitations previously ordered.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. WHITEHOUSE. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll. Mr. WHITEHOUSE. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded. The PRESIDING OFFICER. Without objection, it is so ordered.

ADJOURNMENT UNTIL 9:45 A.M. TOMORROW

The PRESIDING OFFICER. Under the previous order, the Senate stands adjourned until 9:45 a.m. tomorrow.

Thereupon, the Senate, at 7:51 p.m., adjourned until Friday, November 20, 2009, at 9:45 a.m.

NOMINATIONS

Executive nominations received by the Senate:

BROADCASTING BOARD OF GOVERNORS

VICTOR H. ASHER, OF TENNESSEE, TO BE A MEMBER OF THE BROADCASTING BOARD OF GOVERNORS FOR A TERM EXPIRING AUGUST 13, 2012, VICE JAMES K. GLASSMAN, RESIGNED.

WALTER ISAACSON, OF LOUISIANA, TO BE A MEMBER OF THE BROADCASTING BOARD OF GOVERNORS FOR A TERM EXPIRING AUGUST 13, 2012, VICE STRIVEN J. SIMMONS, TERM EXPIRED.

 влиятельный член Broadcasting Board of Governors, VICE JAMES K. GLASSMAN, RESIGNED.

MICHAEL LIVSTON, OF CALIFORNIA, TO BE A MEMBER OF THE BROADCASTING BOARD OF GOVERNORS FOR A TERM EXPIRING AUGUST 13, 2012, VICE MARK MCKINNON, TERM EXPIRED.

SUSAN M. MCCUE, OF VIRGINIA, TO BE A MEMBER OF THE BROADCASTING BOARD OF GOVERNORS FOR A TERM EXPIRING AUGUST 13, 2012, VICE JOAQUIN F. HILDA, TERM EXPIRED.

MICHAEL P. MEEHAN, OF VIRGINIA, TO BE A MEMBER OF THE BROADCASTING BOARD OF GOVERNORS FOR A TERM EXPIRING AUGUST 13, 2012, VICE D. JEFFREY HIRSCHBERG, TERM EXPIRED.

DENNIS MULHAUP, OF CALIFORNIA, TO BE A MEMBER OF THE BROADCASTING BOARD OF GOVERNORS FOR A TERM EXPIRING AUGUST 13, 2012, VICE R. WALTER ISAACSON, RESIGNED.

ERICA M. PERINO, OF THE DISTRICT OF COLUMBIA, TO BE A MEMBER OF THE BROADCASTING BOARD OF GOVERNORS FOR A TERM EXPIRING AUGUST 13, 2012, VICE BRIAN K. ENDSER, RESIGNED.

VICTOR B. ASHE, OF TENNESSEE, TO BE A MEMBER OF THE BROADCASTING BOARD OF GOVERNORS FOR A TERM EXPIRING AUGUST 13, 2012, VICE NORMAN J. FATTUE, TERM EXPIRED.

CONFIRMATION

Executive nomination confirmed by the Senate, Thursday, November 19, 2009:

THE JUDICIARY

DAVID F. HAMILTON, OF INDIANA, TO BE UNITED STATES CIRCUIT JUDGE FOR THE SEVENTH CIRCUIT.